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RISING MEDIGAP PREMIUMS: SYMPTOM OF A FAILING SYSTEM?

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BEFORE THE

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UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

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RISING MEDIGAP PREMIUMS: SYMPTOM OF A FAILING SYSTEM?

MONDAY, JANUARY 8, 1990

U.S. Senate,
Special Committee on Aging,
Harrisburg, PA.

The committee met, pursuant to notice, at 10:15 a.m., in the Senate hearing room, No. 461, State Capitol Building, Harrisburg, PA, Senator John Heinz, presiding.

Present: Senator Heinz, State Senator John Peterson, and State Senator John Hopper.

Staff present: Alison P. Barnes.

OPENING STATEMENT OF SENATOR JOHN HEINZ

Chairman Heinz. Ladies and gentlemen, this hearing of the U.S. Senate Special Committee on Aging will please come to order.

First, I note a very well packed gallery, I suppose it comes as no surprise considering why we're here; namely, to examine the skyrocketing premiums for Medigap insurance coverage.

I don't know of anybody in this State who hasn't received a large number of complaints, particularly if they are in Harrisburg, either in the State House or in the General Assembly.

I know that Senator John Peterson and Senator John Hopper, who chair respectively the Health and Public Welfare subcommittees and the Aging and Youth committees, have received more than their fair share, and I'm deeply indebted to Senator Peterson, in particular, for allowing me to use these facilities of his committee.

Since we are here to talk about Medigap insurance coverage, I would like to observe that in a broader context, these increases are a disturbing symptom of the continuing deterioration of protection under the Medicare Program.

When Congress, very much against my personal desires, completely rolled up the rug on catastrophic health protection last fall, we exposed several weak floor boards in Medicare, weak spots in this Nation's health care program for the aged and disabled.

Elderly Americans, as a result, once again face the potentially ruinous hospital costs of a catastrophic illness and the financially erosive expense of prescription drugs needed to treat chronic conditions.

This also triggered another explosion that demolished the pocketbooks of the elderly. The repeal of catastrophic also resulted in major increases in the premiums for private insurance designed to supplement Medicare coverage.

Last year about 25 million people, or 78 percent of the aged and disabled beneficiaries of Medicare, each spent an average of approximately $705 a year, that's about $59 per month, for insurance to fill the coverage gaps left by Medicare.

Typically these Medigap policies, as they're called, cover the costs of deductibles, doctors, and hospital co-payments. The Medigap crisis, and it is a crisis if your Medigap insurance went up $10, $12, or in some cases as high as $20 a month in this year, is obviously detrimental to those persons who can least afford it.

Retired persons with incomes only slightly higher than Medicaid or the poverty level, people who desperately want to remain independent but because of their limited resources simply may not be able to afford a Medigap policy, are clearly at risk.

So Congress has a responsibility: It's our responsibility to ensure that these vulnerable seniors are not prematurely driven into nursing homes by skyrocketing Medigap rates.

Rising Medigap costs should not be allowed to force seniors to deplete their savings in order to afford Medigap coverage. Yet in 1990, annual Medigap premiums will jump some 20 to 70 percent. I repeat that, in 1990 annual Medigap premiums will jump some 20 to 70 percent.

Now it doesn't take a financial wizard to figure out what might be a financial boom for insurers is a definite bust for seniors living on limited fixed incomes. That's especially true of middle income older people who don't qualify for Medicaid.

Congressional concerns with the Medigap industry are not a new phenomena, many of us have been alarmed by reports of seniors pushed into purchasing multiple policies by high pressure salesmen with suitcases full of horror stories.

Other seniors may actually have an employer provided supplement policy, but pay out-of-pocket for yet another because they're confused about what benefits are provided. Unfortunately, in almost every instance multiple policy equals duplicate coverage, not added protections.

Our witnesses this morning, and I'm grateful to all of them for being here—there are a couple of no shows—our witnesses this morning will be asked to clarify the whys of multi-digit premium hikes.

Is it opportunism in the wake of catastrophic repeal? Is it bad administration or sloppy claims control? Are our State insurance commissioners around the country simply rubberstamping rate requests, or are all the costs fully justified? And how much of it is a result of the repeal of Medicare catastrophic?

We also want to look at what these increases will mean for policyholders. Have we reached the point where middle income indicividuals will have to choose between supplemental health care coverage and the basic staples of daily living like food and heat?

Have gaps in Medigap protections widened too far to span an affordable supplemental coverage policy? And this brings me to my broader underlying concern. When Medicare was enacted nearly 25 years ago, it was the single most significant social legislative initiative ever to pass Congress. This Senator, at least, believes that

Medicare needs to be changed, for too many of America's aged and their families today, Medicare is a confusing and financially cumbersome program.

As former chairman and now ranking member of the Senate Special Committee on Aging and, most importantly, as a member of the Pepper Commission on long-term care and the uninsured, charged with making recommendations on a comprehensive health care system no later than March 1 of this year, I believe we need to examine how Medicare can be changed, both to simplify it and expand coverage, to include much needed long-term care services.

These changes, in my judgment, are coming, I believe they must come. I believe they will come, and they should come, if America is to honor our commitment to quality health care for every senior citizen in this land.

I look forward to hearing our witness' views on what we can do now, both to protect access to comprehensive protection through Medigap insurance and other measures. I welcome our witnesses.

Our first panel of witnesses, is Janet Shikles, Director of Health Financing and Policy at GAO; Constance Foster, the Insurance Commissioner of Pennsylvania; and Peter Archey, Special Assistant to the Executive Director of the Pennsylvania Cost Containment Council.

Miss Shikles, Miss Foster, Mr. Archey, will you please come forward and take your seats.

I'd like Miss Shikles of the GAO to go first, please. Then I'll call on Miss Foster and then Peter Archey.

STATEMENT OF JANET SHIKLES, DIRECTOR OF HEALTH FINANCING AND POLICY, GAO, ACCOMPANIED BY TOM DOWDAL, ASSISTANT DIRECTOR FOR MEDICARE

Ms. **Shikles**. Thank you, Senator. I want to introduce one of my colleagues, Tom Dowdal, who is our Assistant Director for Medicare work in our Washington office, and also, with your permission I would like to have my statement entered into the record and I will just summarize my comments.

Chairman **Heinz**. Very well, and without objection, the statement of every witness will be placed in the record in full and witnesses are always encouraged to summarize ever since I had a witness who neglected to summarize a 30-page single spaced submission. After it was all over, I turned to the witness, in spite of my admonitions to summarize, I said, sir, I want you to know that I am just as ignorant now as when you started. This fellow looked right back at me and said, Senator, ignorant, yes, you are, but surely better informed.

Please proceed.

Ms. **Shikles**. Thank you. We are pleased to be here today to talk about the effect of the repeal of the Medicare Catastrophic Coverage Act of 1988 on premiums for Medicare supplemental or Medigap insurance.

Almost from the beginning of Medicare in 1966 private insurance companies have offered Medigap policies designed to pay some or all of the beneficiary's deductibles and co-insurance.

In 1988 the Congress passed the Medicare Catastrophic Coverage Act, one of the most significant expansions of the program since its beginning. The changes contained in that act significantly reduced the liability of beneficiaries who require a substantial amount of health care services.

In November 1989 the Congress repealed the act and restored Medicare benefits to what they were before the act was passed. As a result of the repeal, Medigap policies must now provide benefits that the insurers did not expect to provide in 1990.

Also, in December, the National Association of Insurance Commissioners revised its minimum benefits standards to require Medigap policies to cover some expenses of policyholders that were not required before, such as Part B co-insurance after the beneficiary pays the annual Part B deductible of $75.

In November 1989 we reported to the Chairman, Subcommittee on Health of the House Committee on Ways and Means on expected Medigap premium changes if the Catastrophic Act was repealed. In our survey at that time we contacted 29 of the commercial insurers that had over $10 million of earned premiums on Medigap policies during calendar year 1987, the latest year for which we had reasonably complete data.

We asked each company to estimate its 1990 premium for its largest selling policy. At that time 20 of the 29 commercial Medigap insurers told us that they expected their premium for Medigap policies to be on average 2.4 percent higher than their 1989 premiums, if the act was not repealed.

Those insurers also told us that they expected to increase their 1990 premium by about 15.4 percent in addition if the act was repealed, which would have been an 18-percent total increase.

In preparation for the hearings today, over the past few weeks we have re-contacted those 29 companies, in order to obtain a more updated estimate of their 1990 premiums and their reasons for premium changes.

Some 20 companies have responded to our latest request and are listed in appendix I to my statement. The policies sold by these 20 companies represent 2.6 million policyholders. The 20 companies now estimate that their 1990 premiums will be on average almost 20 percent higher than their premiums in 1989.

The average increase for an individual will be about $11.44 per month. The individual company increases, however, range widely. From about 5 percent up to about 52 percent. And one company reported that it expected no change in its premium. Appendix II in my statement shows the current estimates from the 20 companies that responded to our survey.

There are several reasons the insurers gave us as to why they expect to increase their premium. General inflation within the medical sector of the economy, increased utilization of medical services, and higher than expected claims experience in prior years accounted for about 10 percent of the increase.

The companies attributed the other half to the repeal of the Catastrophic Act. They said that changes required by repeal include additions to benefits, such as coverage of the Part A deductible or reducing the policy deductible for Part B co-insurance, as well as administrative costs associated with repeal, such as revisions to the policy and notifications to the policyholders. These factors contributed to the rest of the increase. No companies told us they were increasing premiums to catch up because they did not increase or insufficiently increased their premiums in 1989.

The Blue Cross and Blue Shield Association also recently surveyed its member organizations. Thirty-eight organizations responded to their survey, which represented about two-thirds of the Blue Cross and Blue Shield Medigap enrollment.

After summarizing the response, the Association found that the median increase in 1990 nongroup Medigap insurance premiums would be about 29 percent. The association said that a 9-percent increase was projected prior to the repeal of the act.

The Association also identified as reasons for the increase such factors as growth in costs and utilization, benefit changes, and adjustments for prior rate inadequacies.

In summary, many factors are contributing to the increasing premiums for Medigap insurance, but clearly one factor this year has to do with repeal of the Catastrophic Act.

Senator, this concludes my prepared remarks and I'd be pleased to answer any questions you have.

[The prepared statement of Ms. Shikles follows:]

United States General Accounting Office

GAO Testimony

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Monday
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MEDIGAP INSURANCE:
Expected 1990 Premiums after Repeal of the Medicare Catastrophic Coverage Act

Statement of
Janet Shikles, Director
Health Financing and Policy Issues
Human Resources Division

Before the
Special Committee on Aging
United States Senate

SUMMARY

Almost from the beginning of Medicare in 1966 private insurance companies have offered Medigap policies designed to pay some or all beneficiaries' deductibles and coinsurance. Policies may also provide benefits for services not covered by Medicare.

In 1988, the Congress passed the Medicare Catastrophic Coverage Act, one of the most significant expansions of the program since its beginning. The changes contained in that Act significantly reduced the liability of beneficiaries who require a substantial amount of health care services.

In November 1989, the Congress repealed the Act and restored Medicare benefits to what they were before the Catastrophic Coverage Act.

As a result of repeal of the Catastrophic Coverage Act, Medigap policies must now provide benefits that the insurers did not expect to provide in 1990. Also, the National Association of Insurance Commissioners has revised its minimum benefit standards to require Medigap policies to cover some expenses of policyholders that were not required before, such as part B coinsurance after the beneficiary pays the annual part B deductible of $75.

GAO surveyed 29 commercial Medigap insurers in preparation for these hearings. The insurers each had at least $10 million in earned premiums for Medigap policies in 1987 (the latest year for which GAO had reasonably complete data). Twenty insurers responded and told GAO that they expect to increase their 1990 premiums for Medigap insurance by an average of 19.5 percent over their 1989 premiums. The companies attributed about half of this increase to increased benefits and administrative costs necessitated by repeal of the MCCA. The companies said that the other half of the increase was due to other factors, such as inflation, increased utilization of medical services, and prior years' claims experience. For 19 companies, the increases will range from a low of 5.0 percent to a high of 51.6 percent, and one company said it expects its 1990 premium to remain unchanged.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight of these responded, representing two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent.

Senator Heinz and Members of the Committee:

We are pleased to be here today to discuss the effect of repeal of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360) on premiums for Medicare supplemental, or Medigap, insurance. Twenty of the larger commercial Medigap insurers we surveyed told us they expect their 1990 premiums to be an average of about 20 percent higher than their 1989 premiums. The companies attributed about half of this increase to increased benefits and administrative costs necessitated by repeal of the MCCA. The companies said that the other half of the increase was due to other factors, such as inflation, increased utilization of medical services, and prior years' claims experience.

THE MEDICARE PROGRAM AND MEDIGAP INSURANCE

Medicare provides coverage for a broad range of health services for most people 65 years of age or older and some disabled persons. The program has two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physicians, clinical laboratory, X-ray, and physical therapy services. Both parts require beneficiaries to share in the cost of their care through deductibles and coinsurance.

Almost from Medicare's beginning in 1966, private insurance companies have offered Medigap policies to cover some of the out-of-pocket costs incurred by Medicare beneficiaries. Policies may also provide benefits for services not covered by Medicare. Because of abuses identified in marketing Medigap policies, the

Congress in 1980 added section 1882 to the Medicare law. This section, commonly known as the Baucus amendment, sets forth requirements that must be met before a policy can be marketed as Medigap insurance. The Baucus amendment incorporated model Medigap regulations adopted by the National Association of Insurance Commissioners (NAIC) as federal standards. The Baucus amendment retained the traditional role of the states as the regulators of insurance, as long as they have regulatory standards at least as stringent as the federal requirements.

THE MCCA AND ITS REPEAL

The MCCA, which became law in July 1988, provided for the most significant expansion of Medicare benefits since the program's beginning. Beneficiary out-of-pocket costs for covered services were to be capped, and additional services would have been covered when the law was fully implemented.

In June and April 1989, we testified before committees of both houses of Congress on the effects of the MCCA on benefits provided by the Medicare program and Medigap insurance[1]. In both instances, we noted that the MCCA expanded Medicare benefits and thus reduced the coverages required of Medigap policies.

In November 1989, the Congress passed legislation to repeal the MCCA and to restore Medicare benefits to what they were before the Act became effective. The repeal legislation reversed the reduction in coverage required of Medigap policies.

THE EFFECT OF REPEAL OF MCCA ON MEDIGAP POLICIES

As a result of Congress' passage and repeal of MCCA, NAIC revised its model Medigap law and regulation twice. The first revision recognized the changes in Medicare contained in the MCCA. The second revision, adopted in early December 1989, changed the minimum standards to reflect the Act's repeal. The minimum benefit standards for Medigap policies, however, are different from those required before the MCCA was enacted. For example:

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[1] See "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits", Statement of Mr. Michael Zimmerman before the Senate Committee on Finance (GAO/T-HRD-89-22, June 1, 1989) and "MEDIGAP INSURANCE: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums", Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-89-13, Apr. 6, 1989).

-- For services covered under part A of Medicare. Current NAIC standards require Medigap policies to cover either all or none of the part A deductible ($592 per benefit period in 1990). The NAIC standard in effect before the MCCA did not contain a minimum requirement for coverage of the part A deductible, and thus a policy could have covered just a portion of that deductible.

-- For services covered under part B of Medicare. NAIC's current standards require Medigap policies to cover all policyholders' coinsurance for services covered by part B of Medicare, after the policyholder has paid the part B deductible of $75 per year. This coinsurance is 20 percent of the Medicare-approved charge for services. Prior to the MCCA, the NAIC standards required Medigap policies to pay part B coinsurance after the policyholder paid $200 (the $75 annual part B deductible plus $125 in part B coinsurance), and Medigap policies could limit coverage to $5,000 in benefits in any calendar year.

THE EFFECT OF REPEAL OF MCCA ON MEDIGAP PREMIUMS

In November 1989, we reported to the Chairman, Subcommittee on Health, House Committee on Ways and Means, on expected Medigap premium changes if the MCCA were repealed[2]. In our survey, we contacted 29 of the commercial insurers that had over $10 million of earned premiums on Medigap policies during calendar year 1987 (the latest year for which we had reasonably complete data). We asked each company to estimate its 1990 premium for its largest selling policy. At that time, 20 of the 29 commercial Medigap insurers told us that they expected their premiums for Medigap policies in 1990 to be, on average, 2.4 percent higher than their 1989 premium if the MCCA remained in effect. Those insurers also told us they expected to increase their 1990 premium an average of an additional 15.4 percent over what the premium would be if the Congress repealed the Act. In combination, these increases would result in an average increase of $10.64 per month (18.1 percent) over 1989 premiums if Congress repealed the Act. The policies sold by these 20 companies covered about 2.5 million policyholders.

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[2] Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 6, 1989).

In preparation for these hearings, we contacted those 29 companies again to obtain (1) their current estimate of their 1990 premium and (2) their reasons for premium changes.

Twenty companies responded to our latest request and are listed in appendix I to this statement. The policies sold by these 20 companies covered about 2.6 million policyholders. Eighteen of these companies had provided us data for our survey for the Subcommittee on Health. The 20 companies now estimate their 1990 premiums will, on average, be 19.5 percent higher than premiums in 1989. The average increase is $11.44 per month. The increases range from 5.0 percent to 51.6 percent, and one company reported that it expected its 1990 premium to be the same as its 1989 premium. Appendix II to this statement shows the current estimates from the twenty companies.

There are four general reasons why these companies expect to increase their premiums. General inflation within the medical sector of the economy, increased utilization of medical services by senior citizens, and higher than expected claims experience in prior years accounted for about half of the increase. The companies attributed the other half of the increase to repeal of the MCCA. The companies said that changes required by repeal of the MCCA included: (1) additions to benefits, such as coverage of the part A deductible or reducing the policy deductible for part B coinsurance coverage from $200 to $75, and (2) administrative costs associated with repeal of the MCCA, such as modifications to policies and notices to policyholders. No companies told us they were increasing premiums to "catch-up" because they did not increase or insufficiently increased their premiums in 1989.

The Blue Cross and Blue Shield Association also surveyed its member organizations. Thirty-eight organizations responded, representing two-thirds of the total Blue Cross and Blue Shield Medigap enrollment. After summarizing the responses, the Association found that the median increase in 1990 non-group Medigap insurance premiums would be about 29 percent. The Association said that a 9 percent increase was projected prior to repeal of the MCCA. The Association said that plan rate increases reflect numerous factors, including growth in costs and utilization, benefit changes, and adjustments for prior rate inadequacies.

In sum, many factors affect premiums for Medigap insurance. In the legislation to repeal the MCCA, the Congress restored coverage under the Medicare program to what existed before the Act was passed. Repeal of the Act had the effect of placing benefit requirements on Medigap policies that the insurers did not expect to face in 1990. Also, the NAIC has revised its minimum benefit standards to require Medigap policies to cover some expenses of policyholders that were not covered before, such as the lower policy deductible on part B coinsurance.

Senator, this concludes my prepared remarks. I will be happy to answer any questions you have.

APPENDIX I APPENDIX I

INSURANCE COMPANIES THAT RESPONDED TO OUR REQUEST FOR DATA

Prudential Insurance Company of America
United American Insurance
Bankers Life
Mutual of Omaha
Union Fidelity Life Insurance Company
National Home Life Assurance Company
Union Bankers Insurance Company
Standard Life and Accident Insurance Company
The Principal Mutual Life Insurance Company
Pioneer Life Insurance Company of Illinois
Pyramid Life Insurance Company
Associated Doctors Health and Life Insurance Company
Colonial Penn Franklin
State Farm Mutual Auto Insurance Company
Continental Casualty Company
American Integrity Insurance Company
New York Life Insurance Company
Provident Companies
American Republic
Atlantic American Life Insurance Company

APPENDIX II APPENDIX II

EXPECTED INCREASES IN 1990 MONTHLY MEDIGAP INSURANCE PREMIUMS AFTER REPEAL OF THE MEDICARE CATASTROPHIC COVERAGE ACT

Company	1989 monthly premium	1990 expected monthly premium	Increase (percentage)
Company AA	$50.00	$50.00	0.0
Company AB	83.09	87.26	5.0
Company AC	59.93	65.32	9.0
Company AD	73.96	81.29	9.9
Company AE	73.46	80.79	10.0
Company AF	61.65	70.15	13.8
Company AG	68.00	78.00	14.7
Company AH	81.00	94.00	16.0
Company AI	39.25	45.95	17.1
Company AJ	58.75	70.39	19.8
Company AK	68.00	81.52	19.9
Company AL	33.90	41.00	20.9
Company AM	57.65	70.33	22.0
Company AN	38.00	46.36	22.0
Company AO	43.29	53.68	24.0
Company AP	90.00	115.00	27.8
Company AQ	50.82	67.59	33.0
Company AR	43.84	59.67	36.1
Company AS	62.82	90.93	44.7
Company AT	32.95	49.95	51.6
Average	$58.52	$69.96	19.5

Chairman **Heinz**. Miss Shikles, thank you very much for your remarks. I will have plenty of questions for you, but I want to turn right now to our State Insurance Commissioner, Constance Foster.

Commissioner Foster, we thank you very much for being here, we very much appreciate your testimony and after you conclude, I will have questions, but you'll have to wait for Mr. Archey's testimony. Please proceed.

STATEMENT OF CONSTANCE FOSTER, PENNSYLVANIA INSURANCE COMMISSIONER

Ms. **Foster**. Thank you, Senator, since my prepared statement is relatively short, I will cover most of the points contained therein, especially since you had asked me particularly about some other facets of the Medigap insurance, including how we handle consumer complaints and those kinds of things.

There are currently about 140 different Medicare supplement policies approved for sale in Pennsylvania that are offered by approximately 70 insurance companies. Although 140 policies are approved for sale, most Pennsylvania citizens, in fact, purchase their Medicare supplement insurance from the Blue Cross and Blue Shield plans.

Almost 800,000 Pennsylvanians over age 65 are insured under the 65-special plans offered by the various Blue Cross and Blue Shield plans.

For that reason I will begin in detail to explain the effect the changes to Medicare have had on the rate filings submitted by the Blues and then I will go on and discuss the commercial insurance companies.

Let me summarize by saying that in 1988 we received filings from the Blue plans, which in general reflected substantial decreases in their premiums based on the impact of the new Medicare Catastrophic Coverage Act.

In 1989, the story was just the opposite. That year we received requests for very substantial increases, in main based on the repeal of that act.

Let me say that in—when the Blues—you had asked me particularly to talk a little bit about what the Insurance Department does when it receives a rate filing, either from the Blues or from a commercial company subject to our jurisdiction.

Let me say to begin that, first of all, the Insurance Department has jurisdiction to review the rates only of individual Medigap insurance policies. Group policies are not reviewed by the Insurance Department.

When a commercial insurer or a Blue Cross plan submits a rate filing to the Insurance Department, they are required by us to include very detailed information on the major costs and utilization trends for the experience and rating periods for each of the service elements contained in the filing.

In particular such things as deductibles, co-insurance, in-hospital days, outpatient services and skilled nursing facilities. In addition to the actual premium and claim figures the filing also included transferred administrative expenses, risk factors, and subsidy and investment income factors.

Our health insurance actuarial staff with a combined rate analysis experience in excess of 30 years reviews the filings and requests additional information if necessary or clarification of the various elements of the filing.

The submitted information is checked against information contained in other resources we have, such as the annual financial statements required for all insurance carriers and other data sources on health care costs, including CPI reports, actuarial publications, and industry publications.

In addition, this year, as we have in all past years, we've had public informational hearings on these Blue Cross and Blue Shield filings across Pennsylvania located, hopefully, for the maximum convenience of the consumers.

As Congress discovered in the Medicare Catastrophic Act, the cost of providing additional benefits under Medicare is substantial. The shifting of this cost back at Medicare supplement policies did not eliminate those costs, but simply changed the funding mechanism.

Following the repeal, the benefits are being paid for either by consumers, as they were prior to 1989, either directly for those without Medicare supplement policies, or indirectly through the cost of these policies.

To illustrate the impact of the repeal and resulting cost shift to Medicare supplement policies, I have set forth a 3-year rate history for the filings approved by the Insurance Department since the repeal of the act.

I won't go through all these numbers, they are set forth in my testimony, but what they show is a clear pattern, increases in 1988, decreases for the most part in 1989 for the hospitalization piece. And then, again, substantial increases in 1990.

The Blue Shield plan, which covers the physician part of it, was not as impacted in 1989 by the Medicare Act and also, was not, therefore, as dramatically impacted by its repeal in 1990.

Virtually all of both the decrease in the 1989 premiums and the 1990 premiums was due to the passage and then the repeal of the Medicare Catastrophic Act.

Medicare supplement policies of commercial insurance companies are somewhat different than those of the Blue Cross and Blue Shield plans. Commercial policies typically combine benefits for both the Medicare Part A and Part B, which are separated under the Blues.

In addition, these policies are typically noncancelable and the insured are required to undergo very extensive medical underwriting in order to prove their insurability.

There are also differences in the rating methods employed by the commercial carriers and the Blues. Since the numbers of insureds covered under any one policy is substantially smaller, Pennsylvania's experience by itself is generally not credible.

So the commercial carriers typically utilize national loss experience in its rate calculations. Commercial carriers also use different reserving methods and different premium structures that consider the age of the insured at the time the policy is issued. The Department's rate review process is basically the same.

Since the repeal of the Catastrophic Act, 25 filings have been received by the commercial carriers, most of them literally within the last week, the rate increase requests from the commercials range from 10 to 40 percent. None of these filings have yet been approved.

The review of rates is only one function of the Insurance Department regarding Medicare supplement insurance, the Department's Bureau of Consumer Services reviews consumer complaints relating to all lines of insurance.

For the period January 1, 1987, through June 30, 1989, the Department received over 90,000 insurance-related complaints. Of this number, 510 were complaints about Medicare supplement insurance. The vast majority of these consumer complaints related to claims problems and premium charges; 31 of the complaints were about agents, most of which allege misrepresentation. The Department's immediate concern in all complaints is to analyze the problem quickly and aid the consumer in resolving it.

Most consumer complaints are resolved by the consumer service representative through contact with the insurer, billing errors, claim claimant problems, and misunderstandings or failures in communication are most often quickly resolved. One of the key roles of the consumer service representative is to educate individual consumers on the complex issues surrounding Medicare supplement insurance and the pitfalls of not understanding the types of policies that are available.

If a consumer service representative assigned to research a specific complaint detects a violation of the insurance law, the complaint is referred to our Bureau of Enforcement for investigation. The Insurance Department is committed to the goal of increasing the consumer's understanding of Medicare supplement insurance and the role it plays in the health care delivery system.

As noted above, consumer misunderstandings concerning Medicare and Medicare supplement insurance abound. Recognizing the need for increased consumer awareness, late in 1988 I established a new division in the Bureau of Consumer Services dedicated to consumer education. One of the target groups identified as needing special attention was older Pennsylvanians.

During 1989 Department personnel made over 40 presentations to older Pennsylvanians regarding Medicare and Medicare supplement insurance. These outreach programs are scheduled directly with local groups servicing this population, such as area agencies on aging, senior citizens church groups, et cetera.

The programs generally consist of a formal presentation followed by a question and answer session. In addition, the Department works in conjunction with Pennsylvania's Department of Aging to disseminate information such as notification of rate hearings through their network of local agencies.

In addition, the National Association of Insurance Commissioners has recently adopted a model regulation for Medicare supplement policies with very specific protections for the consumer, including requirements prohibiting insurers and agents from selling excessive or duplicate coverage. The Insurance Department intends to promulgate this model regulation.

Thank you. I, of course, am available to answer any questions you may have.

Chairman **Heinz**. Miss Foster, thank you very much for some very interesting and well informed testimony.

Peter Archey.

STATEMENT OF PETER ARCHEY, SPECIAL ASSISTANT TO THE EXECUTIVE DIRECTOR, PENNSYLVANIA COST CONTAINMENT COUNCIL

Mr. **Archey**. Good morning, Senator. I will also use my statement, which is relatively brief.

Medicare and Medigap insurance can only be applied, they cannot be explained or understood. With that comment as a starting point, let me express my thanks for the opportunity to participate in this hearing on a subject important to people of all ages, but with special impact on older people.

Medicare and Medigap are paired, they are not separate, as Medigap by definition fills the gaps in the Medicare program and generally pays only if the services are Medicare approved services.

Without belaboring the point, allow me to present some brief confirmation of the unfortunate confusing nature of the current system and the unchanging structural problems in spite of expanded education, information efforts.

Elizabeth Hanford Dole, then FTC Commissioner at a 1978 congressional hearing stated: "It is difficult enough for anyone to have a thorough understanding of Medicare's complex benefit structure and its gaps."

Now, add to that a bewildering variety of ways each insurer fills some of those gaps. Then, when hospital and indemnity plans and dread disease contracts complicate the picture, comprehension and comparison become almost impossible for consumers. Not much changed in 1986, almost a decade later, with the Harvard Medicare Project Report: "The Medicare program has become so complicated, few elderly Americans understand how it works, what it entitles them to, or even where to go to find answers to their questions. The Medicare program should be simplified so that the elderly and the caregivers can understand it."

The message is simple and consistent. Medicare needs simplification. In a comment I offered as the Executive Director of the Berks County Office of Aging, in a 1979 position paper, I said: "The main reason for the confusion and complexity is the cost sharing system of co-insurance and deductible payments, which have been part of the program since its conception. The co-insurance and deductible provisions are especially complicated and confusing. They produce a real or perceived need for supplemental insurance."

Before I elaborate on simplification of the program, let me note that cost containment and quality identification measures are also essential to either the current analysis of Medigap rates and/or any restructured program.

Medigap rates are directly related to increases in cost and usage of the Medicare Program. Those efforts, on cost containment and quality identification include, but are not restricted to: No. 1, continued indepth review and analysis of rate filings. As indicated, Blue Cross, Blue Shield 65 Special programs are subject to rate approval and often to public hearings, some others are not.

No. 2, expanded interest and participation of Medigap subscribers in those public hearings, which with a few exceptions have been traditionally sparse due to the complexity of the issues. Over 800,000 elderly in Pennsylvania participate in the Blue Cross/Blue Shield 65 Special programs. But, at the rate hearings, which are necessary and important for consumers to understand and for people to explain the program, less than one-tenth of 1 percent statewide subscribers participated in those hearings.

I am from a community (Reading and Berks County). We took pride in having many people participate in rate hearings, so we have a record with that, but it's really been sparse elsewhere, and I think due to the complexity of the issue.

Also, testimony in those hearings should be encouraged which address the information in the rate filing, in addition to the more general testimony.

No. 3, identification of high quality, low cost providers and rewarding them with expanded volume. The Pennsylvania Health Care Cost Containment Council is in the midst of developing and publishing this type of data with Pennsylvania a leader in the country.

No. 4, consideration of managed care approaches consistent with identification of effective providers.

No. 5, continuation of Federal efforts to identify appropriate use of various procedures and developing indicators for consumers, when surgery or medical treatment may or may not be feasible.

No. 6, implementation of the new Medicare physician reimbursement system, which is designed to better reimburse primary care physicians and promote less expensive primary and preventive care.

Now back to the key point addressing the program, which admittedly is confusing, complicated, and little understood, regardless of income or education.

I want to stress these comments reflect my personal views only based on many years of direct and indirect involvement with older people. Restructuring of the Medicare Program to provide understandability is absolutely essential. It is clear that the Medicare Program is not clear.

In spite of counseling efforts by advocacy groups, service agencies, media, legislative offices, the confusion continues, excess coverage and dollars mount, frustration and depression increase, because the basic program is itself confusing and complicated.

The restructuring could be accomplished through a broader coverage effort serving all age groups, including older people such as a national health plan, or a restructuring of a Medicare Program which remains focused only on the elderly and disabled.

Any restructured program cannot ignore revenue needs and sources, as evidenced by the recent repeal of the catastrophic law. This is a crucial, financial, and political reality. I'm enclosing for the record the paper I noted earlier, advocating elimination of Medicare co-pays and deductibles.[1] While some factors have changed, such as physician reimbursement, the paper's focus and thrust remains valid 10 years later, in 1990, with some significant variations.

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[1] See appendix, p. 81.

I am suggesting today the following: No. 1, blending of current Medicare Parts A and B into one which is an effort at streamlining the program and making it more understandable.

No. 2, eliminating the current A and B co-pays and deductibles, or consolidating them into one Medicare deductible, as a maximum use of co-pays and deductibles as a cost-sharing device.

No. 3, providing through the Medicare Program itself the current co-pay deductible gaps for the existing benefit package, eliminating the need for Medigap as it is now structured.

No. 4, financing the expanded Medicare coverage, that is, the gaps, through an actuarially equivalent program premium, in addition to the existing sources of revenues. The major source of financing that premium would be the funds the elderly or employers now pay for Medigap coverage.

No. 5, for those retirees covered by an employer plan, the additional premium could be paid to the Medicare Program by the employer.

No. 6, before any additional and, indeed, worthwhile Medicare benefits are considered, such as prescription drugs or long-term care services, the program streamlining through elimination or consolidation of the current co-pays and deductibles and eliminating need for Medigap as we now know it, must be accomplished.

Otherwise, more confusion is added to the widespread confusion of current Medicare/Medigap combination. Then, insurance might be focused on special needs area such as long-term care, rather than on this basic, simplified acute care program.

Two others: No. 7, the Federal/State Medicaid Program should consider covering elderly and disabled income groups higher than 100 percent of the poverty levels, offering a safety net for the most needy.

Pennsylvania, through provisions of the 1986 Reconciliation Act, has done that. It's a State that should be complimented, the administration and the legislature having acted.

Congress should also consider a higher Federal matching share to assist States with this expanded coverage because of the reluctance of the States to participate with financing costs with the Medicaid Program above and beyond the current limits.

No. 8, the program premium to pay the gaps should be income related. Please note I am not suggesting the wide difference which helped repeal the catastrophic law. However, income related premiums, not income eligibility, is a long overdue principle Medicare needs to adopt, especially if Medicaid eligibility is not expanded.

I hope these comments have been helpful or at least provide some additional discussion. As noted earlier, Medicare and Medigap can only be applied, they can not be explained or understood.

Hearings continue and they are helpful, but the structural problem remains. The elderly continue to pay for excess coverage, older people and caregivers remain confused, service agencies, advocacy groups, congressional offices continue costly counseling programs, the cost of which is not computed in the Medicare Program, either financially or emotionally.

Medigap is a symptom only, of a program which needs massive restructuring so Medicare without Medigap cannot just be applied, it can indeed be explained and understood. Thank you.

Chairman **Heinz**. Peter, thank you very much. And I would particularly thank you for your broader view of the problem and, as I indicated at the outset, the Pepper Commission, which will be meeting next week in Washington on Wednesday and Thursday for 2 days, will be considering exactly this kind of issue.

It's my hope we will come out about where you've come out, with respect to Medicare, and eliminate structurally the kind of gaps, at least recommend to our colleagues in the Congress a reform in Medicare that will remove those kind of gaps that don't make any sense at all.

Let me start with Commissioner Foster. You mentioned in your testimony that your office occasionally gets some complaints and you indicated that you had a moderate number of complaints through June 30 of this year.

Have you had any complaints in the last month or two about the increases in Blue Cross/Blue Shield, Special 65?

Ms. **Foster**. I can't tell you exactly how many. We have gotten a number of inquiries after the rate increases were announced, although I'll tell you quite frankly, and by the way, inquiries into rate increases we do not consider to be consumer complaint, at least not consumer complaints——

Chairman **Heinz**. What are they?

Ms. **Foster**. What I'm trying to explain that, when I'm using the term "consumer complaint," I'm using in it a very specialized sense, which is where we assign a consumer representative to actually investigate the particular policy and its terms with a particular carrier.

We also respond obviously, to what I would call consumer inquiries as to what's happening with rates and why.

And we have received a number of those, but, frankly, I'll tell you, it was many, many less than we had anticipated given our experience when you start seeing numbers and percentages here, and my only explanation for it is, it's hopefully an educated one, is that people did understand in general that Medicare, the Catastrophic Act, had been repealed, and that those costs were going back to the private insurance because, like I said, we got surprisingly few.

Chairman **Heinz**. When would the first invoices reflecting the approval for Blue Cross Special 65 be received, in early January?

Ms. **Foster**. These rates were approved to be in effect as of January 1, 1990, for those three companies so I can only presume the January invoices have already gone out in all of the cases.

Chairman **Heinz**. I assume we'll hear more testimony on that from our next panel.

In general, you mentioned that there are several reasons over time, the cost increases in these premiums, inflation and health care costs being one of them, utilization being another.

What kind of records does the office of the Insurance Commissioner maintain in order to keep track over time of specific increases and the reasons for those increases that Medigap insurers have applied for and received over, say the past 10 years?

Ms. FOSTER. We keep, first of all, the previous filing that the companies have made, together with all of the analysis that the Insurance Department has performed on them.

And a very big part of the examination and evaluation of any filing is looking back at prior filings and checking the information—for example, if there was a trend that was built in, say, to the 1988 filing, a crucial part of examining 1990 is to examine whether the trend that was projected by the plan at that time, in fact, has happened.

And I happened to have brought with me some analysis that we performed on Blue Cross of Northeastern Pennsylvania, one of our plans, and one of the things that we did in that Blue Cross filing is, for example, reduce and almost totally eliminate any further trend projection that they had built into their filing because we felt that the examination historically indicates that perhaps finally, perhaps, we've peaked on the trend and that we would not permit any further trend to be built into these 1990 rates.

Chairman HEINZ. What kind of information, if any, would you have, say, on increases in utilization?

Ms. FOSTER. For?

Chairman HEINZ. For a particular insurer.

Ms. FOSTER. For any particular insurer, we would have really all of the information, both what was projected in any particular filing. And then we would have what actually happened for all of the components of the filing, the deductibles, the co-pays, the skilled nursing facility, we would have all that information available.

Chairman HEINZ. As you point out, that information would be relevant, principally, for the Blues, not for the commercial companies.

Ms. FOSTER. No, I think the same kind of information is crucial to reviewing filings for the commercial companies, it's just that the rating structures are different, they have different methods of underwriting, they use a different data base, but I think the questions are the same.

Chairman HEINZ. Let me ask Janet Shikles—and by the way, I want to commend the General Accounting Office on really a remarkable job of analysis, Senator Roth and I originally asked you for your analysis, just a few weeks ago, and we asked to have it, if possible, by just after the first of the year. It's January 8, you were kind enough to get it to us last week. I hope you had a Christmas holiday and were able to celebrate New Year's Eve. We're most grateful to you, both Senator Roth and myself, for your excellent, excellent work.

Ms. SHIKLES. Thank you.

Chairman HEINZ. Let me ask you about this. Given the skyrocketing Medigap costs that elderly persons are now experiencing, would an enhanced Medicare Program have been a better value or if you would, if the Medicare Catastrophic Coverage Act had not been fully repealed, if we had just gotten rid of the supplemental premium, and the so-called Part B catastrophic, the prescription drug benefit, but retained otherwise the other elements of the program and only the, roughly, $4 monthly premium to finance that—

the so-called flat premium—would the majority of seniors have been better off, both financially and generally or not?

Ms. SHIKLES. They'd definitely be better off under the catastrophic than they are purchasing a supplemental policy.

Chairman HEINZ. Why would that be?

Ms. SHIKLES. It's a combination of reasons, one is that Medicare has very low administrative costs, about 3 percent, and it doesn't do marketing, you don't have the profits involved that you do under, say, commercial carriers and also because Medicare covers about 33 million individuals. Medicare can spread the risk across this large population base whereas a small insurance company has a much smaller population base and that can affect rate increases.

Chairman HEINZ. Would that generalization also be true for Blue Cross/Blue Shield subscribers?

Ms. SHIKLES. Yes, they may not have the same level of profits built in but the factors I mentioned would generally be true for the Blues.

Chairman HEINZ. Aren't Blue Cross costs and administrative costs generally higher, and if so, how much higher, if you know, than say Medicare administrative comparable costs?

Ms. SHIKLES. Well, they would be higher than Medicare, but it would vary by the member organization and I don't have that data.

Chairman HEINZ. Would you have any information on that, Commissioner Foster?

Ms. FOSTER. Yes, I do, Senator. I happen to have, in fact, in front of me, from 1988, the expense factors for the plans here in Pennsylvania.

For Capital Blue Cross, it was 4.81 percent. For Blue Cross of Northeastern Pennsylvania, 3.84. Western Blue Cross, 5.12, Independent 7.08, and Blue Shield, 9.43.

I don't have all of the 70 carriers in front of me, commercial, but I would guess that these are—in fact, I would say more than guess, these are substantially lower than the same expense provisions than you would see for a commercial carrier, mainly because they don't pay commissions.

Chairman HEINZ. My understanding of the pay out of commercial insurance companies relative to premiums is for Medigap, about 60 percent?

Ms. FOSTER. That's correct.

Chairman HEINZ. Which gives you the idea of the size of their marketing and selling and other costs?

Ms. FOSTER. Right. And the pay out on the Blues would exceed 90 percent.

Chairman HEINZ. Peter, would you care to wade into this discussion as to whether seniors are better off or worse off with repeal of the Medicare catastrophic?

Mr. ARCHEY. I think that there were a lot of economic impact studies done, as you know, Senator, that indicated when you take a look at the total program and you look at all the participation from the Government with the Part B financing and everything else, there was sufficient reasons financially for most people to have some benefit from it.

I think the problem, as I indicated in my material, is that many people still felt they still had to have Medigap insurance, and I think the other issue and, which is a problem because it just adds on to the current confusion as I note.

That was the same thing with the drug program, which was going to cover approximately 16 percent of the subscribers with the cost distributed across. Many people felt that was disproportionate.

I think, however, that—and I also feel that one of the major positive factors of the catastrophic program was its impact on beginning an income related premium, however, I think, as people well know, that the range of that, particularly with the surtax or the supplemental tax, was broad enough where that became a major political liability and major political issue.

Chairman HEINZ. People greeted that, I would think it's fair to say, with a modest amount of enthusiasm.

Mr. ARCHEY. Less than overjoyed, Senator.

Chairman HEINZ. That's right.

Mr. ARCHEY. I think the thrust to an income related premium was very positive, yet I think it obviously was not focused enough or it was too broad for people or high enough for some people to be able to strongly oppose it.

I'm not sure, also, I mean my view, frankly, as I know it is, that I would like to see the basic program focused, financed similar ways as I mentioned and then begin to add some other benefits, whether it's prescriptions or long-term benefits, I think the basic program needs that.

Chairman HEINZ. Commissioner Foster, a couple of questions about your, as I say your excellent testimony, I note that—in my copy of your testimony, the headings of the columns got somehow erased, what is the first column, is that central or what, on page 4 of your testimony?

Ms. FOSTER. Yes, page 4, the first column is Capital Blue Cross of Central, the second column is Northeast and the third column is Western.

Chairman HEINZ. Just looking at Blue Cross Special 65, what you have over a 2-year period is an average increase of some 13 percent, that is, to say you had 16 percent in 1988, 14 percent reduction and then a 40 percent increase in 1990. And by my rough calculation, that means that had you not had—had we not enacted Medicare catastrophic, you would have had—otherwise had a cost increase of somewhere around 13 percent in 1990; does that sound about right to you?

Ms. FOSTER. I think so. I didn't bring my notes here, but I think the 2-year increase was approximately 17 percent, if you ignore the decrease from 1989.

Chairman HEINZ. Since we're comparing apples and apples, when we talk about what I referred to earlier as a cutback catastrophic program, Blue Cross and Blue Shield doesn't deal with the part——

Ms. FOSTER. Blue Shield does. Blue Cross doesn't.

Chairman HEINZ. Blue Cross Special 65, I misspoke, doesn't deal with part B. If we had retained the so-called basic benefits under catastrophic, not the Part B, not the prescription drugs, do you think that seniors would have had less in the way of out-of-pocket costs in 1990 than if that basic package had been repealed?

Ms. FOSTER. Again, I have some specific information as to that. That but for the repeal, the rate increase for capital, which it requested, now mind you, we probably or likely would have approved less, was 6 percent and 0 percent for both Northeast and Western. Because what happened is they had filed first with the act in place and then amended their filing in order to reflect the repeal. So we know exactly what those numbers would have been. If I could just add——

Chairman HEINZ. Let me just put that in perspective for a moment. The so-called flat premium for the basic—for Medicare catastrophic was scheduled to rise by, if my memory serves me, about 90 cents, from 1989 to 1990; does that sound right?

Ms. FOSTER. Right.

Chairman HEINZ. So the additional out-of-pocket costs, had we not repealed the basic benefit as well as the surtax and the prescription drugs and the Part B catastrophic, would be 90 cents compared to—there would have been that and, in addition, in terms of Blue Cross Special 65, the increases would have ranged from 0 percent in two cases to 6 percent, 6 percent would be—that was Capital, was it?

Ms. FOSTER. That was Capital.

Chairman HEINZ. You might or might not have granted the entire 6 percent.

Ms. FOSTER. That's right.

Chairman HEINZ. Would have been about $1.20 a month maximum and probably a good deal lower. Instead what people are faced with are increases averaging or depending whose statistics you take, anywhere from $9 to $11 a month.

And in some cases here, they're $7 or $8, in the case of these three Blues.

Ms. FOSTER. That's correct. And what I'd like to do is just add on to something that Pete Archey said, too, and the other thing, in addition, to the out-of-pocket costs, which obviously are very significant.

The other thing that the Catastrophic Act had done is take a significant step towards making Medicare, at least a little bit more understandable with the elimination of these deductibles and copays, you know, after that first period, particularly, in the in-house hospitalization.

And now we're right back to, you know, you have the $592 deductible and then you have one co-pay that kicks in at the 31st day and another co-pay that kicks in on the 90th day, which doubles again, and those are—bringing those back, I can tell you in trying to explain to the consumer those aspects of it, I just want to reiterate that I think one of the most important things that Congress can do is to make this program understandable for our older citizens.

It's a nightmare from our viewpoint in trying to explain to them. And then try to explain to them what the various kinds of Medigap insurance might be and how to compare it.

Chairman HEINZ. Do you have any more to add to that, Miss Shikles?

Ms. SHIKLES. No, I just think that her point is very valid, that policy complexity, you know, contributes also to some of the consumer abuse problems, where people don't understand their policies and that's why I think we're seeing people purchasing multiple policies because they're afraid and they end up buying extra policies, which they really don't need, as you mentioned earlier, and they don't get any benefit from that.

Chairman HEINZ. Is it everybody's impression that people were going to—let me turn that around. If the analysis that we've all been talking about is correct, that seniors would have been out-of-pocket better off if the basic Medicare Catastrophic Program had been retained, along with the repeal of the surtax and prescription drugs and Part B, do any of you want to try to account for why senior citizens requested that Congress act against their apparent best interests? Peter?

Mr. ARCHEY. I guess I will try that, first. Many of the people sitting in back of us are from Reading and Berks County. We had a session about 2 months after the program was created, an information session attended by approximately 200 people.

It was an all day session. A number of us were involved in trying to explain the program. That program also was complicated, because we explained a surtax which they didn't have before.

Catastrophic put a cap on Part B services. It did, indeed, as the Commissioner said, begin to focus or eliminate—it eliminated the hospital co-pays, but it retained the hospital deductible.

It also added another set of co-pays and deductibles with the prescription program. So in explaining it, we were explaining it with that program, not the more basic, the stripped down versions, so I think that was part of the confusion.

The other part is people were simply not prepared to pay that kind of surtax. I think those are the complexity issues in trying to explain it.

Second, there was going to be a necessity to retain, possibly, some Medigap for the hospital deductible, for the Part B cap, the Part B co-pay, and also possibly for the prescription, so it added to the confusion; and third, there was reluctance to pay the surtax route only by the elderly and without the use of general funds.

Chairman HEINZ. What you're saying, it was horribly confusing?

Mr. ARCHEY. Yes.

Chairman HEINZ. I don't think there's much disagreement on that.

Let me ask Janet Shikles one question regarding multiple Medigap policies. Of the seniors who have Medigap policies, my understanding is about one in six or one in seven have a second or even more policies.

Is there any reason for somebody to have more than one Medigap policy?

Ms. SHIKLES. No, there is no reason. They shouldn't purchase more than one policy.

Chairman HEINZ. Commissioner Foster, I see you nodding more or less in agreement. Do you agree with that?

Ms. FOSTER. Absolutely, and one of the things I like very much about the new NAIC model regulations it really tries to deal with that by putting some very strict burdens on agents who are selling this coverage to determine whether or not there's a policy already in effect, and if so, to disclose it.

When I talked about our 510 complaints, Senator, let me make it clear that I think what we get is the tip of the iceberg, that this is so confusing and people don't know and, I think, indeed, there are many, many Pennsylvanians out there who could use our help but don't even realize that they need it.

So I think 510 is probably less than 1 percent of the people who need consumer education and consumer help in this area.

Chairman HEINZ. If my statistics are right, there's some 4 to 5 million seniors in the United States who are the alleged beneficiaries of multiple Medigap policies.

Let me ask Peter Archey and Janet Shikles what else should we do to try to prevent people from buying coverage that they don't need or to help people avoid buying coverage that they don't need?

Mr. ARCHEY. Senator, I think you continue the efforts to help educate people under the current program, I think there's been notice and mention made today of the various efforts to do that.

That is just trying to put a bandaid on a problem. You have to change the basic program and make it understandable. I go back to when Medicare was started. People went out into neighborhoods to try to get people to sign up for the program in 1965 and 1966, and then Medigap came into it. I don't think the confusion has abated. The basic program has to be changed and made more understandable.

Chairman HEINZ. Miss Shikles.

Ms. SHIKLES. I agree with the comments, the NAIC standard adopted in December may begin to help. But the States have to adopt the standard, and then the agents have to adhere to it, the standard, and be committed to making sure that the elderly person really understands that they don't need to purchase another policy.

And often, they don't understand it or the agent has such an interest in selling the policy that they aren't quite careful in making that explanation.

Chairman HEINZ. Is there anything more we should do, should we just make the NAIC do it, I mean—I can't predict what Peter Archey wants to do, or what I want to do in terms of reforming the Medicare Program. I suspect, however, it's highly unlikely we will pull that off this year, so we're going to—even if we enacted legislation this year, it would take several years for it to go into effect.

Mr. ARCHEY. I think as an option you just have to do more and more education in more and more places by more and more people on the basic program. That's an interim and short-term step but it doesn't solve the structural problem.

Chairman HEINZ. Is there, any of you, is there any incentive for an agent to adhere to the NAIC, these new NAIC standards?

Mr. DOWDAL. It's now supposed to be gotten in writing that the beneficiary doesn't have another policy, and, you know, that is fairly hard for an agent——

Chairman HEINZ. When you say now, do you mean——

Mr. DOWDAL. When the States adopted it.

Chairman HEINZ. As of January 1, 1990, if the States adopt the NAIC standard?

Mr. DOWDAL. Right, and you are dealing with 50 States, they will have variations on it and things like that. But, generally speaking, most of the States adopt those standards, so, of course, enforcement of the stuff varies from State to State.

Chairman **Heinz**. The answer is there is no known incentive other than the fact that if a State adopts it and if the salesman does it and if he gets caught, there might be some kind of sanctions imposed upon him.

Mr. **Dowdal**. It's better than the former one where you had approved knowingly selling it, which is very difficult to do. Now they have to get a positive affirmation from the person that they didn't. There's ways that if somebody wants to be, you know, devious, they can get around that, too. But it's certainly better than what existed in the past.

Chairman **Heinz**. Very well, I'd like to thank all of you. You participated and have given us some very helpful and excellent insights into the issue of these insurance rate increases. I want to particularly thank Commissioner Foster for being especially well informed on these matters, to GAO, who worked literally night and day during the playoffs and those of us from Pittsburgh are feeling a little sadder today, about like Philadelphia felt earlier.

Mr. **Foster**. Last week.

Chairman **Heinz**. And to Peter Archey for his tireless and also tremendously foresighted views of things, anybody who wrote something in 1979 that is still relevant today was clearly not writing about Communism in Eastern Europe.

Mr. **Archey**. It may indicate my patience rather than my sense, Senator.

Chairman **Heinz**. You have been an excellent group of witnesses, I'm deeply indebted to you all, on behalf of the committee, our appreciation.

Our next witnesses, Mr. Harry Frantz, Mrs. Helen Kushner, and Mr. Thomas Coe, please come forward.

Mr. Frantz, thank you, again, for being here. Will you please proceed?

STATEMENT OF HARRY FRANTZ, CONSUMER SPECIALIST, BERKS COUNTY SENIOR CITIZEN COUNCIL, INC.

Mr. **Frantz**. My name is Harry Frantz, I'm the consumer specialist for the Berks County Senior Citizen Council, Inc., an organization of 80 senior citizen clubs with over 16,000 members.

We are located in Berks County, PA. Part of my job is assisting senior citizens who have Medicare and Medigap policies.

Prior to my current position I worked for the Social Security Administration for over 35 years, 30 years in supervision and management. I retired as the manager of the Social Security office in Reading.

I wish to thank you for the opportunity to testify about the problems senior citizens have with Medicare, Medigap, and health care costs. The repeal of the Catastrophic Health Insurance Act will be a disaster to most low-income senior citizens. Because many insurance companies have not yet analyzed the additional cost to them or sent out new premium notices, it is much too early to forecast the number of complaints that will be received.

I have received numerous calls from people who have received their new Blue Cross/Blue Shield 65 Special rate notices and are asking if I know of any cheaper policies available.

Chairman HEINZ. Mr. Frantz, could I ask you to suspend just a moment while I introduce Senator John Hopper, representing at least in part Cumberland County, and I'm not sure I know all of John's representations and responsibilities, but somebody I have known for many years and, of course, Senator Hopper serves as the Chairman of the Aging and Youth Committee, if I got that right, John.

Senator HOPPER. You're right.

Chairman HEINZ. I'm the aging, he's the youth here today, in case there's any wondering.

Senator HOPPER. Thank you.

Chairman HEINZ. John, thank you for being here. Do you have anything you you'd like to say?

Senator HOPPER. No, not at this point, I'd be interested in hearing what goes on. Thank you very much.

Chairman HEINZ. Mr. Frantz, thank you very much for stopping.

Mr. FRANTZ. Many of these persons are considering dropping their policies. Although I am not permitted to recommend any special policy I can and do advise them of the dangers of switching policies because of waiting periods and preexisting conditions clauses and before they know what steps other companies are going to take.

I also review the provisions of any policy they have or are considering and explain how they are integrated with Medicare. The persons contacting me are desperate. Many have an income only slightly higher than Medicaid limits, they want to be independent. One 90-year-old who contacted me was forced to use some of her savings to meet her expenses last year. With a 40-percent increase in her Blue Cross and Blue Shield and expected increases in rent, her savings will soon be gone.

Another lady in her 80's was collecting aluminum cans to supplement her income, she had previously dropped her Medigap insurance, because she could not afford the cost and came to me for help because she couldn't afford the 10-percent increase in her rent.

In October the Pennsylvania Insurance Commission held a hearing to review the request of Pennsylvania Blue Cross/Blue Shield to increase their rates.

We testified at that hearing that senior citizens could not afford the 10 percent increase in Blue Cross 65 Special and 20.3-percent increase in the Blue Cross extended program.

For a short time we were very happy, because they were only granted half the increase requested, which is more in line with the cost-of-living increases. However, when the Catastrophic Health Insurance Bill was repealed, they asked for an additional 38 percent and received 35 percent for a total of approximately 40 percent.

In our testimony, we explained that in 1977 the out-of-pocket health care of elderly citizens was $712. By 1988, the amount had escalated to $2,394 per person, nearly two and a half times the cost just 11 years earlier.

In percentages it went from 12 percent to 18.1 percent of disposable income. At the current rate the cost will be over 20 percent in a short time.

It is clear that this trend cannot continue, a copy of my testimony at that hearing is attached.

I am concerned that the repeal of catastrophic health insurance will precipitate an increased onslaught of insurance agents selling Medigap policies to older persons who do not understand, and who are not able to make adequate comparisons between policies of different and even of the same company.

To illustrate how helpless many elderly persons who are living alone can be, one woman came to my office with the story of her mother. Though Pennsylvania law requires an insurance salesman explain that only one Medigap policy is necessary and additional policies are only duplications, this explanation is often omitted or the client doesn't understand.

In this situation, the woman had six Medigap policies when a seventh insurance man arrived. He explained he could save her money if she dropped the other six and purchased his policy, which she did.

Subsequently, however, additional salesmen arrived, at which time the daughter contacted me. Her mother had accumulated three new policies. When asked why, the mother simply said, but he was such a nice young man.

I'm afraid that in 1990 a lot of duplicate policies will be sold by unscrupulous insurance men who do not explain that duplicate policies are unnecessary or if they drop one policy for a new one, there could be waiting periods or preexisting conditions that can leave them without protection for a period of time.

I strongly urge that simplification of language and uniformity of the descriptions of covered items become mandatory so that a comparison of coverage and cost can be made more easily.

The catastrophic health insurance repeal is a real tragedy, although I concede that financing provisions or at least the method of financing was poorly explained to the public. The repeal of this act will cause a great increase in the cost of Medigap policies as already shown by the Blue Cross/Blue Shield extended increases. We can be certain similar increases will follow for other Medigap policies. I fear many senior citizens will be forced to drop their insurance and rely on Medicaid when medical indigency develops.

Unfortunately, the additional premium or surtaxes, as it was commonly named, became the rallying cry of all the dissidents and, I'm sorry to say, they included me. On the surface, it did not seem fair to single out a special group to pay of the needy a certain age group.

By this same rational, however, only people with children should pay school tax. In essence, this explanation set a bad precedent. In fact, if we look at Medicare financing closely, we see that the seniors covered by Part B are those already being subsidized. They are paying only 25 percent of the actual cost of this insurance, $27.90 for 1990.

They are, therefore, receiving a subsidy of $83.70 or $1,004.40 a year. This is a larger amount that the maximum surtax, I believe if an explanation had been given that individuals would not be given as large a subsidy from general taxes, rather than describing it as a surtax, there would have been a greater degree of acceptance.

The original law required only a 50-percent subsidy rather than 75 percent. If this provision had remained in effect, people would have already been paying $346.86 more per year and this would be without catastrophic or prescription drug protection.

Admittedly a great deal of objections came from people who were fortunate enough to be receiving free or subsidized catastrophic health insurance from their former employers and, therefore, did not see any value of the provisions.

Special taxing provisions could have been made for these persons, and I might add here, Pete's suggestion that the employer could have paid what they're paying for the Medicaid tax could have been used for this purpose. The best procedure would have been to give a better explanation of the benefits of the act and explain that persons with larger incomes would not be receiving as great a subsidy.

As time goes on and health costs continue to escalate, more and more companies are dropping or reducing their retiree health insurance plans. In a few years objections from that group will be reduced or eliminated.

Congress should consider reinstating many of the provisions of the Catastrophic Health Act. If this is not done, more and more senior citizens will be forced to drop Medigap policies and rely on Medicaid for emergency health care.

Eventually with escalating health care cost for everyone, a national health care system may become the only solution. Thank you.

Chairman HEINZ. Harry, thank you very much for some excellent testimony and it takes a well informed big guy to have a change of heart, you were both, and I thank you for your insights.

Helen Kushner is our next witness who has come down from Freeland, PA, Luzerne County. Helen, we are delighted you are here. Thank you for coming.

STATEMENT OF MRS. HELEN KUSHNER, FREELAND, PA

Mrs. KUSHNER. Thank you for having me. Last month I wrote you a letter with my problem with Medigap insurance costs and I'm glad to be here.

I have Medigap insurance through Blue Cross and Blue Shield of Pennsylvania. It's not a policy with a lot of frills, but I'm grateful for the Pennsylvania PACE program, as I am on medication for arthritis, high blood pressure, and a potassium supplement.

My Medigap premium for Blue Cross Special has gone up $37 a month. With Medicare and Medigap to date, I'm actually paying $95 a month for health insurance.

Chairman HEINZ. As I understand it, your Blue Cross Special is going up $37 a quarter.

Mrs. KUSHNER. A quarter, right.

Chairman HEINZ. Or about $12 a month.

Mrs. KUSHNER. I'm sorry there.

Chairman HEINZ. If it is, you are in worse trouble than you thought.

Mrs. KUSHNER. I know I am. People in my situation living on Social Security and maybe a small pension, they really have to stretch their money. I get along on $443 Social Security, $168 from

Amalgamated Clothing Workers after working 36 years making men's shirts.

Out of that $611 a month I have to pay part of my expenses at home: electricity, water, coal, and heat. I live in a rural area and the phone, newspaper, and TV service are important to me. Once those bills, the groceries, the property and school taxes are paid, there is actually nothing left over.

At the present time I can manage, but when costs go up, I cannot help thinking about the time I won't be able to afford to maintain my home. I was born in the house I live in. I live with my brother, now at 82, but all our days are numbered. When I'm alone again, I know I won't be able to stay in the home.

It wasn't just the increases in the rates that was on my mind when I wrote to you, Senator Heinz, I asked you to come up with another catastrophic bill to help the seniors like me, the one that just got repealed was defeated by the wealthy, not by people in my situation.

If there is another catastrophic bill, I hope it will have the kind of home health that would help me—keep me out of a nursing home. Because of my arthritic condition, I may wind up in a wheelchair and in a nursing home because there will be a few important things I will not be able to do for myself. I hope you and the other people in Congress will think about that this year.

But I cannot do without the Medigap policy. I need the protection from the risk of medical bills. If I don't have anything else, I must maintain that, but I want you to know, Senator Heinz, that paying the cost of the protection is getting harder and the benefits we are getting from Medigap and Medicare aren't the kind of help that will help me be independent at home where I want to be as long as I can. Thank you.

Chairman HEINZ. Helen, thank you very, very much for a very—not only a statement that was clear, but crystal clear and certainly about a million times clearer than that catastrophic legislation.

Mrs. KUSHNER. That I don't understand.

Chairman HEINZ. Welcome to a very unexclusive club, I'm sorry to say.

Our last witness on this panel is Mr. Thomas Coe, who has been working in the vineyards for many, many years, representing the interests and concerns of senior citizens and is here on behalf of AARP, the American Association of Retired People.

STATEMENT OF THOMAS L. COE, SR., PENNSYLVANIA STATE LEGISLATIVE COMMITTEE, AARP

Mr. COE. Good morning, my name is Thomas L. Coe, Sr., I live in Pittsburgh, PA.

I am a member of the American Association of Retired Persons State Legislative Committee chaired by Mr. M. Francis Coulson. The subcommittee on long term care is chaired by me, and long term care, that's a whole other issue of concern laying on the desk of our Congress and in the State assemblies going tick, tick, tick.

I'm testifying here today at the request of Mr. Coulson on behalf of our American Association of Retired Persons and our State Legislative Committee.

First, permit me to thank the Hon. Senator Heinz and Mr. Jeffery Lewis, Republican Staff Director and their staff, for the opportunity to testify on this all-important issue of rapidly rising Medigap insurance coverage.

As we enter this new year we are once again confronted with costly Medigap fee increases that will relegate many of our citizens to the ranks of uninsured. Senator Heinz stated at the Pennsylvania Conference on Rural Health held in Dubois, PA, on September 18, 1989, that 37 million Americans lacked basic health insurance. And recent surveys have shown that over 1 million uninsured live in Pennsylvania.

I am not here to protest the Medigap carriers annual appeal for rate hikes. I hope to learn as a result of this hearing what is being done to solve the problems that make these annual rate increases necessary.

Naturally, we sympathize with those concerned about insurance costs getting beyond their ability to pay; on the other hand, we cannot deny the carriers the revenue needed to remain solvent. We do expect them to operate in an efficient, fiscally responsible manner, and that they be candid in their explanations for fee increase needs.

Mr. Gus P. Georgiadis, Blue Cross senior vice president, said that repeal of the Catastrophic Medicare Act was responsible for a 35-percent increase in the 65 special rate.

The other 3 percent being due to the increase in hospital deductible cost from $5.60 to $5.92. If repeal just takes us back to where we were, then why should this be so?

The act's repeal, in addition to rising health care costs, was a factor considered in granting the increase according to Insurance Commissioner Constance P. Foster. Up to this date the U.S. medical profession has defeated all efforts at cost control.

For-profit hospitals, and surgeons, seem to know no bounds relating to charges for services. And as long as Medicare approves these charges, the Medigap carrier is mandated to pay their 20 percent share and the more they are required to pay the more they must charge their subscribers. Even some in the medical profession are becoming embarrassed when called upon to explain why an ophthalmologist should earn $1,750 for a 45-minute cataract operation.

The efficiency generated by the recent vast strides being made by technological advances in surgical procedures are not being passed on to the patient.

The Physician Payment Review Commission created by Congress in 1986, the Harvard study of how the Government pays physicians for treating Medicare patients, the great number of media articles on the high cost of medical care in the United States, as compared to other advanced nations, as well as this hearing, all are indicative of our need to face this issue.

We as a nation cannot further delay our responsibilities of providing access to affordable adequate and quality medical insurance and care for all of our U.S. citizens, in spite of our exorbitant national debt and the increasing erosion of our middle class, our per capita income makes us the richest, and our technology makes us the most advanced nation in the world.

In our position as a world leader nation, which we have assumed, we should also strive for improving the well-being of our citizens, as well as those of less fortunate countries.

According to a December 22, 1989, Pittsburgh Press article by Mr. David Morris, Americans spend more on health care than any other developed nation, and get less in return.

In addition to the 37 million lacking any kind of health insurance, there are 20 million more who are significantly underinsured. For those over 65, Medicare covers less than one-half of their medical expenses and another shocking revelation was that one-half of all personal bankruptcies are caused by illness.

Surely, we cannot permit this to continue, and all things considered, it seems that the annual increase in Medigap insurance rates, as well as that the annual increase in Medigap insurance rates, as well as those in our Medicare Program, are the effect, with the runaway provider costs being the cause, in our cause-and-effect equation.

In closing, we would like to confess to not being experts in either the field of medicine or insurance. Our position is that for the good of all, those who are experts should get together and solve this problem as quickly as possible. Thank you for your patience.

Chairman HEINZ. Mr. Coe, thank you very much, let me just say in terms of trusting the experts, there is a view that the Medicare Catastrophic Act was cooked up by experts and that the constituents had a serious voice in what should be done with that expert, shall we say crock pot contents that was there. So, I feel certain that you are—you will give the experts a chance, but not all the rope with which you might get hung.

Let me ask starting with Mr. Frantz. Mr. Frantz, you described in your testimony a lady with some six Medigap policies; is that right?

Mr. FRANTZ. That's correct.

Chairman HEINZ. Had you encountered that kind of problem very often?

Mr. FRANTZ. Yes, but not to that extent. I've been in this position for approximately 2 years, that was the worst example that I had.

But I have numerous people who come in with two or three policies, some come in with one Medigap policy and some specialized insurance, like cancer policies that are really not too good or policies that pay so much per day in the hospital in addition to the Medigap policy. They aren't technically called Medigap policies, but they are duplications.

Chairman HEINZ. Do you think the new standards of the NAIC as they become adopted will help solve this problem?

Mr. FRANTZ. Yes, but—to a smaller degree, as I think was testified before. A lot of elderly people are influenced when someone comes to their door, has a nice personality, sympathizes with them and tells them about their policy. I'm not sure how many insurance men who are unscrupulous will suddenly change.

Some of them might, but a lot of them will give the same story and, again, it's going to be the insurance agent's word against the claimant's word that an explanation was given. There are usually only two people present and it's hard to prosecute them because of that.

Chairman **Heinz**. Moving on to Medigap policies and catastrophic benefits, obviously, you, yourself, were among those as you indicated, who, for quite some time felt we should repeal the entire program, there are a lot of people like you, Congress, in fact, did repeal the entire program. The public debate about catastrophic was very one-sided.

Yet, as we learned today and as you, yourself, indicated in your testimony, there probably was a good solution here that could have been worked out, if you will, the Senate version, the so-called McCain provisions probably represented a pretty good piece of public policy that would have given people a good value and would not have retained the lightning rod surtax, which, as it was structured, was too, I think so-called progressive to be sustained.

Why was the public debate, nevertheless, about catastrophic kind of all or nothing with everybody saying nothing, why was it so one-sided.

Mr. **Frantz**. First of all, I want to correct one statement, I wasn't against the catastrophic health insurance. I was against one provision, the surtax provision.

Chairman **Heinz**. Right.

Mr. **Frantz**. One of my jobs is to give talks to senior citizens groups, explain Medicare and so on. As Pete Archey said, in Berks County, I think we probably do a better job than most areas, because we are all out talking to the people, we have various groups who help people. Most of the people who are against it are the people who have good pensions. Their employers are paying for part or were paying for the entire health insurance costs. They couldn't see any benefit to themselves.

Chairman **Heinz**. The duplications issue is a serious one——

Mr. **Frantz**. Right.

Chairman **Heinz**. That was certainly true.

Mr. **Frantz**. Very serious. And because a lot of them had maybe slightly higher income that the average, they were more articulate, they could express their views, they grouped together, and they contacted their Congressmen, and Senators. I think that had a great influence because they were more verbose on the issue.

I don't think the average person really understood the catastrophic health insurance at all or the benefits they were going to lose if it was repealed.

I suppose I didn't really change until I saw the danger that the entire bill was going to be repealed, this really got me upset, personally, and I started looking at the financing. As I said in my testimony, senior citizens are already getting over $1,000 a year subsidy. No matter how wealthy they are, they are getting that $1,000 supplement for Part B.

Chairman **Heinz**. Was there any active attempt by anyone, by any groups you know of to actually mislead senior citizens about the Catastrophic Act?

Mr. **Frantz**. No, I wouldn't say so. I don't think even the ones who came out against it really understood all the provisions, especially the financing provision. I think that almost every argument against it was based on the surtax. I think all the opposition was based on the surtax.

Chairman HEINZ. Helen, you indicated that you're going to have to somehow absorb that $12 or so monthly increase, how are you going to do that?

Mrs. KUSHNER. Well, actually I guess first of all, I will have to cut down on some of the—it's not really unnecessary, but like the newspaper, which we buy newspapers daily and on the weekend, on Sunday. That amounts to about $12 or $15, then the next thing I probably have to cut down is on my food bill. Where else am I going to go?

Chairman HEINZ. You're right at the margin right now?

Mrs. KUSHNER. Right.

Chairman HEINZ. You're going to, just as Harry indicated, it's important to be well-informed, the first thing you're going to have to give up is being as well-informed as you are now?

Mrs. KUSHNER. I'm not well-informed, but I do know that the catastrophic bill was defeated and not by me.

Chairman HEINZ. You're here testifying at a Congressional hearing, I think you're doing pretty well. You're informing me.

Mrs. KUSHNER. Thank you. I guess my food bill would be my main thing.

Chairman HEINZ. I'll tell you, that gives you an idea. Do you have a sense of what forces were at work to entirely repeal the Medicare catastrophic, would you share Mr. Frantz' views?

Mrs. KUSHNER. Yes, I would.

Chairman HEINZ. Mr. Coe, how about yourself?

Mr. COE. The benefits were great. The way it was capitalized is what people were concerned about.

It was like property tax, it was stacking in a vertical manner the revenue necessary to service the people that needed the benefit rather than on a horizontal over greater area of source of revenue. And this—if I go out in the for capital market to buy insurance, that's an option I have, I go out and buy insurance I can afford to pay for.

But if somebody comes along to me, here, you have to have this insurance and we're going to take it out of your income to pay for it, that's not an option. That's socialization, when a socialization occurs, the cost has to be spread over the many.

Chairman HEINZ. Let me ask you on a related subject: I indicated earlier that we're going to be at work over the next several months, I hope, in redesigning the Medicare Program. And you hold the very important position as chairman of the AARP committee on long-term care.

Mr. COE. A very frustrating position to hold.

Chairman HEINZ. Would you be willing to work with me and my staff as we try and come up with a redesigned Medicare Program?

Mr. COE. I'd be more than glad to.

Chairman HEINZ. You're on. I'm not going to let you forget that.

One last question for Mr. Frantz. Mr. Frantz, you said in your testimony that Federal retirees pay the same premium for their Medigap policies as they pay—as they paid or they pay for their full health insurance program preretirement. Now, I realize that no one—maybe you aren't complaining about the Federal Medigap policy, but it does strike any observer that extraordinary Medigap would cost the same as full benefits preretirement. Can you explain why those benefits cost that much?

Mr. **Frantz**. No, actually as I said——

Chairman **Heinz**. How many years did you say you worked for the Social Security Administration?

Mr. **Frantz**. Thirty-seven.

Chairman **Heinz**. So you understand a lot of this stuff.

Mr. **Frantz**. I understand Medicare pretty well.

Chairman **Heinz**. But you don't understand this?

Mr. **Frantz**. No, I don't understand that particular provision, as I say it really started when Federal retirees were not under Medicare and did not have Medicare. People had long-term employment for the Government. The Government continued health insurance coverage for employees into retirement.

About 4 years ago or 5 years ago, Federal employees had a new pension system developed, which included Medicare coverage. I don't think anyone ever looked at the fact that Medicare is now paying a large percentage of health costs but that retirees continued paying the same premium. No one raised the question of why retirees should pay the same premium now that Medicare is going to pay a large proportion of medical costs.

Chairman **Heinz**. At least that is what you think?

Mr. **Frantz**. That's what I think. Basically, the reason I didn't complain is that although I'm paying more proportionately than some people, when I compare what I'm paying into the Federal health employee system to what people have to pay for Medigap policies for a family, it's not too bad in comparison.

Chairman **Heinz**. You're getting a pretty reasonable deal. How much a month is it, roughly?

Mr. **Frantz**. Around $50 or $60 for Blue Shield low standard option, and that includes my wife. So, you see, it's for two of us, and that includes catastrophic insurance, and drug—prescription.

Chairman **Heinz**. Comparing it on other comparable policies it's a reasonably good deal.

Mr. **Frantz**. Yes, even with the fact that I am paying as much as current employees.

Chairman **Heinz**. Very well. Listen, I want to thank all three of you, Harry Frantz, Helen Kushner, and Tom Coe for being here. I very much appreciate your attendance.

You are giving us a very crystal clear feeling of what it's like to be on the receiving end of these changes of policy and increases in premiums, and Helen, especially, thank you very much for indicating from your own personal experience how close to the line so many of our senior citizens are.

No one wants any of our senior citizens to have to go without food, to have to cut back on being informed, to—or to be put at risk of having to end up in a wheelchair or go to an institutional setting when the alternatives might be available.

You've given the committee, I'm sure a lot to remember, I'm most grateful to you. As I am to both Tom Coe and Harry Frantz. Thank you all very much.

Let me call at this point, our fourth panel: Gene Ott, Patrick Rooney, and Bob Polilli.

While I note that there are no representatives on our third panel who are here, we do have testimony from Martha McSteen, the President of the National Committee to Preserve Social Security and Medicare, her testimony will be entered into the record.[2] General J.C. Pennington, retired, the Executive Vice President of the National Association for Uniform Services, who, like the National Committee to Preserve Social Security and Medicare, were instrumental and very aggressive in getting Congress to entirely repeal the Medicare catastrophic program, not just the surtax but any vestige thereof.

Let me at this point welcome Gene Ott, Patrick Rooney, Bob Polilli and ask Gene if he would please start off.

STATEMENT OF EUGENE J. OTT, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER OF INDEPENDENCE BLUE CROSS

Mr. OTT. Thank you, Senator Heinz, ladies and gentlemen, good morning. My name is Eugene J. Ott, I am Executive Vice-president and Chief Operating Officer of Independence Blue Cross.

It is my privilege to be here and to represent some 1,700 employees who are my coworkers. Independence Blue Cross has been based in Philadelphia for more than 50 years. We are a nonprofit health insurance company which insures our subscribers for hospital and hospital related expenses.

We serve approximately 2 million subscribers throughout the five counties of southeastern Pennsylvania. Those counties are Bucks, Chester, Delaware, Montgomery, and Philadelphia.

For the past 23 years Independence Blue Cross has offered high quality Medicare supplemental coverage to Medicare beneficiaries in southeastern Pennsylvania. Today we have 209,000 Medicare beneficiaries covered under our individual Medicare supplemental programs.

We are pleased to have this opportunity to appear before the Special Committee on Aging and to give you a brief overview of Independence Blue Cross programs for our Medicare beneficiaries.

At the same time, I'd like to reemphasize our more than 50 years of service to the community and our commitment to continuing that service in the years ahead.

At Independence Blue Cross we view service to the disabled and elderly in our area as not a business, but as a central part of our social mission as health care insurers. We are as dedicated to serving them as we are to serving our customers in the more competitive group market.

I have to point out at this time that historically our coverage for the over 65 and medically disabled beneficiaries have not been a profitable line of business, even with significant subsidies.

It is also most important to point out as mentioned by Commissioner Foster that unlike the commercial insurers we accept all applicants who apply to us.

I emphasize all applicants. We do not turn away those who may be in poor health. We do not use medical screening or individual underwriting to deny coverage to those less-fortunate individuals with disabling injuries or illnesses.

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[2] See appendix, p. 88.

Unlike many Medigap insurers, our Medicare supplemental programs are available not only to those Medicare beneficiaries who are over age 65, but also to those Medicare beneficiaries who are under age 65, but are entitled to Medicare benefits because of a certified medical disability.

Traditionally these people have higher utilization and are shunned by other insurers. Just in reviewing the 1987 and 1988 statistics, these people have used twice the amount of insurance than the other Medicare beneficiaries have used.

Independence Blue Cross stands ready to offer them health insurance at the same rate and with the same benefits as all other Medicare beneficiaries. We also provide open enrollment all year long so that consumers in our service area can sign up at any time. We do not age rate, which means that the subscriber will pay the same premium, whether they are 66 or 86.

We do not rate these programs by area, which means that our Medicare supplemental programs provide the same benefits at the same price regardless of the community or neighborhood where they reside.

We are proud that we can offer our Medicare customers a number of conveniences, convenient walk-in customer service in our center city office. Senior citizen consultants who go out and speak to the senior citizens, and payment arrangements through neighborhood banks.

But I would like to emphasize one that we consider unique in our area, it is our electronic paperless claim system. Through our special contractual relationship with hospitals we process and pay hospital claims for our subscribers without them having to fill out lengthy claims forms, forms that can be confusing to a 34-year-old, let alone an 84-year-old widow with failing eyesight. From personal experiences, I know of neighbors with insurance policies where claims must be submitted on paper.

Often the elderly or Medicare beneficiaries do not the submit the claims, paying out of their pocket from dwindling savings, because they just do not understand the forms.

They may save other insurers money, but it's money the elderly can ill afford to waste. Also approximately 25 percent of our subscribers have multiple policies, because of our ease of processing and paying claims, other insurers are billed, therefore, reducing their overall costs.

In our efforts to educate our beneficiaries on health insurance and health care costs, Independence Blue Cross encourages them to carry only one policy—avoiding paying double premiums and being over-insured.

We also stress the significance of using physicians and other providers who accept Medicare assignment, saving the beneficiaries additional out-of-pocket expenses.

I mention this because frankly we're very conscious of the dollar and cents that have been entrusted to us of premium payments and we're particularly conscious of those we receive from our Medicare supplemental customers.

One more significant measure of the quality of any Medigap product is the percentage of premium dollar that is paid out in benefits for those insured Medicare beneficiaries. Since 1981, Independence Blue Cross has averaged paying out a dollar or more in benefits for every premium dollar paid in by our Medicare beneficiaries.

This, we believe, is part of our social responsibility and commitment. Our most recent estimated figures for 1989, showed that we paid out 94 cents in benefits on behalf of our Medicare beneficiaries for every premium dollar paid in. This does not include administrative expenses.

As you heard earlier this morning, the Pennsylvania Insurance Department regulations require that 60 cents in benefits be paid out for every dollar received in premiums. Since premiums often are not enough to cover the cost of the program, our Medigap supplemental product is subsidized by additional charges to our group customers. That subsidy has risen from $1.7 million in 1980 to $8.2 million in 1990.

I've given this overview to explain our commitment to continue to offer a high quality, fiscally sound Medicare supplemental policy in a socially conscientious manner.

I would now like to present some of the factors that have caused Independence Blue Cross to reluctantly ask the Pennsylvania Insurance Department for an increase in premiums for our Medigap program.

Chairman HEINZ. Let me just ask you at this point. We've got to keep testimony to 5 minutes, as I think everybody knows, you have taken about 5, can you—I'm going to ask everyone to summarize their testimony in 5 minutes, because that was, I think, the request that the staff made of you, otherwise I'm just going to have to start cutting people off, because we can't run past 12:15.

There's some important questions that have to be asked of everybody. Could you please summarize the rest in a minute or two? I'm sorry to do this to you, I just have to stick to the rules that we established.

Mr. OTT. I appreciate that, Senator. The only other point I've raised in the remaining testimony——

Chairman HEINZ. Let me assure you, your testimony in its entirety will be a part of the record. It will all be there, I've read it all, so not to worry.

Mr. OTT. The only other point I have detailed in the testimony was where the money was coming from in the terms of the additional premium requirement and that if we do not get any rate relief at all, we will lose about $33 million on premiums of $66 million. Thank you.

[The prepared statement of Mr. Ott follows:]

Committee Hearing

"Recent Increases In Medicare Supplemental Insurance Rates"

10:00 AM
January 8, 1990 (Monday)
Senate Hearing Room 461
Main Capitol Building
Harrisburg, Pennsylvania

Statement By

EUGENE J. OTT

Executive Vice President
&
Chief Operating Officer

of

INDEPENDENCE BLUE CROSS

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Unlike many Medigap insurers, our Medicare Supplemental programs are available not only to those Medicare beneficiaries who are over 65 but also to those Medicare beneficiaries who are under 65 years of age but are entitled to Medicare benefits because of a certified medical disability. Traditionally these people have higher utilization and are shunned by other insurers. Independence Blue Cross stands ready to offer them health insurance at the same rate--and with the same benefits--as all other Medicare beneficiaries.

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We do not rate these programs by area, which means that our Medicare supplemental programs provide the same benefits at the same price regardless of the community or neighborhood where they reside.

We are proud that we can offer our Medicare customers a number of conveniences:

- A convenient walk-in Customer Service,
- Senior Citizen Consultants,

and,

- Payment arrangements through neighborhood banks.

But I would like to emphasize one that we consider unique in our area.

> It is our electronic paperless claims system. Through our special relationships with hospitals we process and pay hospital claims for our subscribers without them having to fill out lengthy claims forms--forms that can be confusing to a thirty-four year old--let alone an 84 year old widow with failing eyesight.

From personal experience, I know of neighbors with health insurance policies where claims must be submitted on paper--often the elderly or Medicare beneficiaries do not submit the claims--paying out of pocket from their dwindling savings because they just do not understand the forms. This may save other insurance companies money--but its' money the elderly can ill afford to waste. Also approximately 25 percent of our subscribers have multiple policies but because of our ease of processing and paying claims, other insurers aren't billed, therefore, reducing their overall costs.

In our efforts to educate our beneficiaries on health insurance and health care costs, Independence Blue Cross encourages them to carry only one policy -- avoiding paying double premiums and being over-insured. We also stress the significance of using physicians and other providers who accept Medicare assignment -- saving the beneficiary additional out-of-pocket expenses.

I mention this because frankly we are very conscious of the dollars and cents that have been entrusted to us in premium payments and we are particularly conscious of those we receive from our Medicare supplemental customers.

One of the more significant measures of the quality of any Medigap product is the percentage of premium dollars which is paid out in benefits for those insured Medicare beneficiaries. Since 1981 Independence Blue Cross has averaged paying out a dollar or more in benefits for every premium dollar paid in by our Medicare beneficiaries. This, we believe, is part of our social responsibility and commitment.

Our most recent estimated figures for 1989 show that we paid out $.94 in benefits on behalf of our Medicare beneficiaries for every premium dollar paid in. This does not include administrative expenses. The Pennsylvania Insurance Department regulations require that 60 cents in benefits be paid out for each dollar received in premiums. And since premiums often are not enough to cover the cost of the program, our Medicare Supplemental product is subsidized by additional charges to our group customers.

That subsidy has risen from 1.7 million dollars in 1980 to 8.2 million dollars in 1990.

I have given this overview to explain our commitment to continuing to offer a high quality, fiscally sound Medicare Supplemental policy in a socially conscientious manner. I would now like to present some of the factors that have caused Independence Blue Cross--reluctantly, to ask the Pennsylvania Insurance Department for an increase in premiums for our Medigap program.

This increase is necessary if we are to continue to serve our Medicare customers in a fiscally responsible manner--and if we are to continue to be able to provide them the benefits--the security--they need.

I also want to point out that the circumstances under which we found it necessary to request a rate increase are radically different from circumstances a year ago when we reduced our Medigap premiums by 18.8 percent. Independence Blue Cross was one of the few Blue Cross Plans to do so, due to the expansion of the Medicare program.

I recognize that this fact may be difficult to understand for some of our subscribers and others, who saw a rate reduction for 1989 followed 12 months later by a proposed rate increase for 1990.

Recently we asked the Pennsylvania Insurance Department to approve an increase in the premiums for our Medicare Supplemental Products of $10.85. This increase should be taken in the context of the substantial benefit change that occurred with the repeal of the Medicare Catastrophic Coverage Act; the dramatic increase in the deductibles and copayments for 1990; as well as our 18% premium reduction in 1989.

Let me give you an example. The premium per month for Independence Blue Cross 65-Special currently is $23.05. If the Medicare Catastrophic Coverage Act had not been repealed, we would have asked for a 4.8 percent raise in rates amounting to a monthly premium of $24.15.

But the repeal of the Medicare Catastrophic Coverage Act will cost an additional $10.85 a month for our older subscribers. Here are the reasons why:

> The deductible under the Medicare Catastrophic Act had been one per calendar year. Now, there is a deductible required per every benefit period, which means that Medicare beneficiaries may be subject to multiple deductibles in a single year.
>
> Since 17.5 percent of hospital admissions are for the second or subsequent admission, we now must cover the deductible on these additional cases. It should also be noted that the deductible increased from $560.00 to $592.00. This adds $2.53 to the monthly cost per subscriber.
>
> Under the Medicare Catastrophic Act, since hospital days were unlimited, no co-payment was required. With the repeal, we cover the co-payments of $148.00 per day for the 61st through the 90th day, and $296.00 per day for the 91st through the 150th day. The monthly cost for this benefit is $3.92 cents per subscriber.

Under the Medicare Catastrophic Coverage Act, the skilled nursing facility co-payment would have been $27.50 per day for 8 days. Now with the repeal, we pay a co-payment of $74 per day for days 21 through 100. The additional cost of this benefit change is $1.57 per subscriber per month.

Independence Blue Cross provides an additional 365 days of hospital or skilled nursing facility care beyond that covered by Medicare with our Medicare supplemental program. This truly catastrophic coverage was available to our beneficiaries prior to the Medicare Catastrophic Coverage Act and we believe is the type of benefit that provides a safety net for those vulnerable individuals. The additional cost to cover these days is $.41 per month.

Skilled nursing care days covered were those beyond the 150 days covered by Medicare under Catastrophic. With the repeal, days beyond 100 are covered by our Medicare Supplemental Program. Our additional cost for this benefit is $.46 per month.

Under Catastrophic, medical and outpatient expenses would have been subject to an out-of-pocket cap of $1,370. Since this limit no longer exists, our liability increased $1.56 per subscriber per month.

The net result of all of these dramatic changes to our Medicare Supplemental Products because of the repeal of the Medicare Catastrophic Coverage Act is over $10.00 per month per subscriber. The new rate, if approved by the department, will be $35.00 a month. All of these actuarial figures that I have presented this morning have been reviewed and verified as accurate and correct by the nationally recognized actuarial firm of Milliman and Robertson, Inc.

We do not enjoy raising health insurance rates for anyone, particularly for our older subscribers. But we simply had no choice with the repeal of the Medicare Catastrophic Coverage Act.

Without this increase, Independence Blue Cross projects a loss of $30 million dollars on the $66 million premium dollars received in this program.

Senator Heinz, I want to thank you and the members of the committee for giving me the opportunity to appear before you today.

I know health care--and health care costs and benefits are of deep concern not only to everyone in the Philadelphia area--and the commonwealth--but to virtually everyone in the country. We offer you our complete cooperation in your important task--and will eagerly await your report on the results of these hearings.

Chairman HEINZ. Thank you very much, Gene. Let me now call on Mr. Patrick Rooney, the CEO of Golden Rule Insurance Co.

STATEMENT OF J. PATRICK ROONEY, CHIEF EXECUTIVE OFFICER, GOLDEN RULE INSURANCE CO.

Mr. ROONEY. Yes, in respect to the matter of rate changes specifically relating to the onset of catastrophic care or the repeal of catastrophic care, these are the rate changes that we had in 1989, because of the repeal of catastrophic care: Our "Basic" policy, which is the bare bone Medicare supplement, had a 5-percent reduction. Our "Medigap-Plus," which is a policy that covers prescription drugs and excess doctor charges, had a 2-percent reduction.

But at the same time in 1989, as has been in every other year, there have been congressionally mandated increases in the Medicare deductible, so the cost of the additional benefits required to pay the Medicare deductible were these pluses here of 5 percent and 4 percent. But for 1989, we need netted it out at zero change in rates because of the onset of catastrophic care and the change in the Medicare deductible.

For 1990, those same rate reductions will come back, they got 5 percent off over here. Now they'll get 5 percent more. They got 2 percent off over here, and now they'll get 2 percent more.

Incidentally the dollar amount of these increases is approximately the same. The percentages vary because the Plus policy, which covers prescriptions and excess doctor charges, is a more expensive policy.

But then for 1990, again, there will be a change in the Medicare deductible, which brings about an additional 9 percent (or up to 9 percent) on the Basic policy and up to 6 percent on the Plus.

So, adding these changes together, only part of which are due to the repeal of catastrophic care, the Basic policy (the bare bone policy) will have a change of 10 to 14 percent for 1990 and the Plus policy will have a change of 7 to 9 percent for 1990.

Neither of those policies is currently available in Pennsylvania. At the beginning of 1989 we filed with the Pennsylvania Insurance Department to meet with their regulatory requirements, changes in the policies, for the advent of catastrophic care.

That was not acted upon by Pennsylvania until in November, when we received notice that it would be approved by the compliance department, it will now be sent over to the actuarial department.

In December the actuarial department of the Pennsylvania Insurance Department advised us, well, how, catastrophic care has been repealed, should we—do you want to withdraw this whole thing and start from scratch. And yes, we decided to do that, but the result of the regulatory environment in Pennsylvania is, as we have decided, it is not worthwhile to continue to offer our policy.

I want to point out to you, if you read Consumer Reports, they rated our Medigap plus as best buy, but it isn't available in the State of Pennsylvania.

Now, out of consideration—I can comment on the subject of the Catastrophic Care Act but I'm willing to quit, if you'd like me to.

Chairman **Heinz**. It's a deal. Thank you, I'll give you an opportunity to comment in response to questions.

[The prepared statement of Mr. Rooney follows:]

TESTIMONY BY J. PATRICK ROONEY, CEO
OF GOLDEN RULE INSURANCE
BEFORE THE SENATE SUB-COMMITTEE ON AGING

JANUARY 8, 1990

HARRISBURG, PA.

The first issue I would like to address is the increased cost to Medicare supplement policyholders because of the repeal of Catastrophic Care Act. Golden Rule offers two policies, Medigap Basic and Medigap Plus.

A number of sources have suggested that there will be significant, even exorbitant, increase in Medigap policies because of the repeal of Catastrophic Care.

My reply is simple: That's Baloney!

I have brought along charts which illustrates the savings due to Catastrophic Care in 1989, the increase due to the repeal of Catastrophic Care, and the extra costs due to the increased deductible and how it effected our national rates for 1989 and 1990.

Several factors have contributed to premium increases in 1990:

1. The increasing average age of policyholders.

2. The Congressionally mandated increase in the size of the deductible in Medicare. (Most Medigap policies pay 100% of the deductible and therefore the policies offer increased coverage every year.)

3. Medical Services Inflation.

4. The widespread use of ever more complex and expensive medical procedures.

5. And, for 1990, the repeal of Catastrophic Care Act.

So how important is the last item?

My company's experience is that the part of Catastrophic Care that was effective in 1989 would have resulted in lowering the premium for Medigap Basic and Medigap Plus by less than $3 per month. We would have implemented this change except that the increase in Medicare Deductible would have forced us to raise our premiums by about the same amount.

This year we will be seeking increases in the neighborhood of $5 - $10 per month across the country. Most of these increases are not due to the repeal of Catastrophic Care. They are due to increases in the Medicare Deductible and the other factors listed above.

I would like to point out that these increases are the same for Medigap Basic, and our premium policy Medigap Plus.

Medigap Plus is one of the best, most comprehensive Medicare supplement policies available. Consumer Reports rates it a "Best Buy". Golden Rule probably processes claims faster than anyone else in the industry. Its coverage is far more extensive than Catastrophic Care was ever intended to be.

For 1990 the total increase for our National Standard policies, due to all the factors listed above, will be less than 9% for those under 70 and 7% for those over 80. The middle age groups (70 to 80) face increases between those two percentages.

So, why the talk about exorbitant increases? It is no secret that a number of health insurers are under severe financial strain.

I suggest that these large proposed increases are an effort, by some insurers, to recover their own health using the convenient excuse of Congressional mischief. The fact is that they may never again have a political opportunity of this magnitude.

I would like to take this moment to offer some comments on the philosophy behind the Catastrophic Health Care law.

I opposed it and welcomed its repeal because I do not think it was good public policy.

Medicare now provides basic coverage for 60-day hospital stays.

The big issue that this nation is going to have to deal with in connection with medical care is when to shut it off.

No senior citizen that I know of who is still thinking, still has the mental capacity -- no senior that I know of, wants to be kept alive for a year in a vegetative state. I certainly don't. I signed a living will last week to prevent that very kind of thing.

Now, as a matter of public policy, we should not be forcing that on senior citizens. It is better that we enable the terminally ill to die comfortably. And the fact is hospitals, who have their own financial problems, will make it difficult to end treatment as long as Uncle is paying the bill.

> Acute care, the kind of care that is rendered in the hospital, ought to be stopped at the end of 60 days. If you can't in that time frame get people well enough to go home and enjoy their grandchildren, maybe that won't be productive, but at least they should be able to go home and enjoy the grandchildren, then we should acknowledge the terminal nature of the illness and place individuals in a nursing home and allow them to die comfortably. It is not good policy to spend the fortune that we can, and sometimes do, spend on hospital care to keep somebody artificially alive.
>
> Such care, if available, should be voluntary. If the person wants to buy that extension benefits, let him buy it, but let's not force this upon all of us as a matter of public policy.
>
> Frankly, I considered Catastrophic Care to be a form of welfare for hospitals rather than medical care for seniors.
>
> Lastly, since I am testifying in the State Capitol of Pennsylvania, I am inclined to remark on the unique situation in Pennsylvania. Golden Rule has one of the best Medicare Supplement policies on the market, at least Consumer Reports thinks so, because they rated us "Best Buy".

Today, we are not writing that policy at all in Pennsylvania because of their regulatory environment here. We're now in 1990, and at this point in time, our actuaries and the Pennsylvania Insurance Department have still not agreed on the rates for our Medicare Supplement that were to take effect in January of 1989 -- January, a year ago.

The reality is the transaction cost of doing business in Pennsylvania is so great that we have stopped marketing out Medicare Supplement. This product, that Consumer Reports says is a "Best Buy", cannot be bought by the citizens of Pennsylvania from Golden Rule because of the cost of doing business in Pennsylvania.

We do have other products that are written in Pennsylvania but, frankly, we shed a tear over every policy we write here because we know that the transaction cost of doing business here is so great.

I believe, and I'm the Chief Executive, that we either must write a ton of business in Pennsylvania so that we can afford to have several full-time lawyers and full-time actuaries to spar with the Department of Insurance of Pennsylvania, or we should write no business (or as little business as we possibly can). We have chosen the latter course.

There are other companies that sell our products here, but we sure don't push it. We don't have any regional marketing offices in Pennsylvania, but we have four of them in Ohio.

The effect of the Pennsylvania regulatory environment is to create monopoly conditions for the few companies that decide that they can or must cope with this Department of Insurance.

Let me explain it to you this way: You don't have to be efficient in Pennsylvania. You only have to be able to convince the Insurance Department that you charge enough money to cover costs and a little bit more. The Pennsylvania Insurance Department will fix the company up with a market in which it will be one of the few suppliers.

Blue Cross in Pennsylvania does not have to worry about Golden Rule as a competitor. They do not have to worry about the fact that Consumer Reports thinks Golden Rule is the best because Golden Rule isn't available in Pennsylvania, and it isn't available in Pennsylvania because of the regulatory environment. We simply find it too costly and too uncertain.

Suppose we wrote 100,00 Medigap Plus policies in Pennsylvania? Then, by God, we could not afford to have a year's delay on rate adjustments. We would have to bring the thing to a swift conclusion, or we would have to write off an immense loss in the state of Pennsylvania. We can't afford to do that, so we believe that the risk in Pennsylvania is not worth it. We choose to put our efforts elsewhere. Places where we can understand the rules of the game.

The crusading profile of the Pennsylvania Department of Insurance, and it has a national reputation in this regard, is having the long-term effect of reducing competition and driving up the costs for Pennsylvania's consumers.

Medicare supplement policies are not cheap and the factors listed above indicate that they will not become cheap in the future.

However, there is intense competition. Consumer Reports rated 28 major companies and there are a dozen more. Except for states like Pennsylvania, which pursue monopolistic insurance systems, the free market will guarantee a range of reputable plans at competitive rates.

Thank you.

Chicago Tribune, Sunday, October 22, 1989 Section 1

Elderly may pay for fighting tax

By Elaine S. Povich
Chicago Tribune

WASHINGTON—Senior citizens are likely to end up paying private medical insurance premiums that are even higher than the Medicare catastrophic health care surtax, which many of them want scrapped.

Congressional analysts say premiums for those "medigap" policies, which are designed to pay for costs not covered by Medicare and are sold so successfully on TV by personalities such as Ed McMahon and Danny Thomas, could jump as much as 70 percent if the catastrophic-care act is repealed or drastically cut back, as now appears likely.

Exactly how high the premiums go depends on how much of the catastrophic program is eventually saved, but actions by the House and Senate so far indicate that little, if any, of the program is going to be left at the end of this year.

The House repealed the program entirely and the Senate voted to scale it back drastically. Both houses scrapped the surtax. House-Senate differences will have to be worked out.

Most of the senior citizens who lobbied against the surtax were the more affluent seniors, many of whom also have medigap insurance.

"Private medigap policies were not going to have to pick up the costs that were going to be shifted over to Medicare catastrophic," said Rep. Henry Waxman (D., Calif.), one of the House's most knowledgeable members on health issues.

"Now that the catastrophic bill, for all practical purposes, is over, there will be a dramatic increase in the premiums people are going to have to pay for medigap," he said.

The castastrophic care program offers a wide range of benefits designed to keep elderly Americans from sinking into poverty if they become seriously ill. It includes unlimited hospitalization, a $1,370 limit on yearly doctors bills and a $600 annual lid on prescription drug bills.

Max Richtman, a lobbyist for the Committee to Preserve Social Security and Medicare, the senior citizens group that worked hard against the catastrophic program surtax, said the group didn't really discuss what would happen to medigap insurance rates if it succeeded.

Richtman conceded that poorer seniors, those who would have gotten Medicare catastrophic coverage for free, probably can't afford any medigap insurance.

"They will be out of luck," he said.

Alan Spielman, director of government relations for the Blue Cross and Blue Shield Association, whose members offer more than 100 medigap policies, predicted that repeal "will result in a significant increase" in the cost of premiums.

He added, "The magnitude of the increase depends on the final product."

For example, the Congressional Budget Office estimated the actuarial cost of providing the benefits of the Medicare catastrophic health insurance coverage at $255 for 1990.

That means if a private insurance company were going to offer the same benefits as the catastrophic-care program, it would cost the consumer not only $255 more but also an approximate 25 percent markup to cover the company's profits and administrative costs and a 15 percent inflation factor for a total of about $365 a year extra.

A spokeswoman for Mutual of Omaha, a major medigap insurance provider, said the current annual cost for a typical medigap policy in Illinois is $43.29 a month, or $519 a year. If that cost rose by $365 a year, it would mean an increase of more than 70 percent.

That means the total cost of the policies next year is likely to top the $800 maximum surtax paid by the more affluent elderly for the government's catastrophic health insurance.

A congressional committee staffer, using figures provided by an insurance company that asked anonymity, predicted that a typical medigap policy in a Midwestern state would rise from the current $54.50 a month to $67.50 a month, or $810 a year, with total repeal of the Medicare catastrophic program and the effects of inflation. That's nearly a 25 percent hike.

And, since most medigap policies do not cover all of the things that the catastrophic plan would have covered, seniors effectively could be paying more for less.

While the private sector contends it can provide services in general more efficiently than the government, a program such as Medicare catastrophic would not increase costs substantially because the government infrastructure for it already exists.

Those who conceived the Medicare catastrophic program said that fact would tend to make it less costly for the government to administer catastrophic care than for private companies.

Supporters of the catastrophic-insurance program contend it was confusion that led to the senior citizens' demand that the program be scrapped and the surtax ended.

Under the program, Medicare recipients are assessed a surtax, based on income, up to $800 annually for the wealthiest recipients, to pay for the program.

Only 5 percent of the recipients paid the highest surtax, but many more thought they would have to pay the maximum. More than 60 percent of the elderly paid little or nothing.

Rep. Harris Fawell (R., Ill.), an ardent supporter of the repeal forces, contended that the senior citizens who lobbied Congress for repeal knew that they were going to see higher medigap rates as a result.

But, he said, they were satisfied to have the choice of whether to buy the private insurance, unlike the government program, which was mandatory.

"They were saying, 'Okay, sure, we can cope with that,'" Fawell said.

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MEDICARE CUTBACK EXPECTED TO ADD TO PRIVATE RATES

INSURERS SEEK INCREASES

Premiums May Rise by 10% to 43% to Offset Changes in Federal Coverage

By MARTIN TOLCHIN

Special to The New York Times

WASHINGTON, Oct. 25 — Insurance experts and members of Congress say millions of older Americans will face higher health insurance costs if Congress repeals or cuts back the Medicare program that pays for the catastrophically high costs of a major illness.

The higher expected costs would come in the form of higher premiums on policies offered by many private insurers to cover the difference between the total cost of an illness and what the Government pays under Medicare.

The planned Medigap increases were not unexpected by the health insurance experts. Private insurers had said earlier this year that they were holding down increases because many benefits had been picked up by the Federal program. The proposed increases are subject to approval by individual state insurance regulators.

Increases Up to 43%

Industry officials and members of Congress said in interviews over the past two days that private insurers have proposed or plan to propose increases in premiums ranging from 10 percent to 43 percent to compensate for an anticipated increase in coverage if Congress, as expected, repeals or sharply curtails the program to pay for major illness.

The officials said they could not precisely estimate the number of older Americans who would face higher payments, but they noted that 25 million of the 33 million Medicare recipients carry the additional insurance.

Congress passed the Medicare Catastrophic Coverage Act in June 1988 to help older Americans avoid financial ruin from the cost of a major illness after President Ronald Reagan proposed the plan. But Congressional curtailment is near because of strong protests from elderly taxpayers opposed to the income tax surcharge that helps finances the program.

Sullivan Opposes Repeal

President Bush has not taken a position on the issue. But Dr. Louis W. Sullivan, Secretary of Health and Human Services, is opposed to repeal of the program.

Some of the companies are waiting final Congressional action before proposing the amount of their increases. The legislation is now before a Senate-House conference committee. The House voted to repeal the program that places a ceiling on elderly patients' payments for hospital and doctor bills and would pay much of the cost of prescription drugs. The Senate voted to retain only the hospital benefits.

Under the program, an elderly American who earns more than $15,000 annually pays the minimum surtax, which is $22.50 for every $150 of income taxes paid, while an elderly citizen with an income of more than $35,000 pays the maximum of $800. The program is also financed by a $4 monthly premium deducted from the Social Security checks of all Medicare beneficiaries.

Many of those who pay the surtax said they resented paying to finance a

Continued on Page 9, Column 1

Higher Medigap Premiums Seen if Medicare Plan Is Curtailed

Continued From Page 1

program that duplicates the private coverage they have as retirement benefits.

Congressional authorities estimate that about 20 million elderly taxpayers with incomes below $15,000 would receive the benefits under the program without paying the surtax. This group is among those who now face the prospect of going without Medigap policies or having to pay for benefits they would have received under the Government program at little cost.

Very Poor Are Unaffected

Insurance industry officials said that repeal or curtailment of the program is unlikely to affect the very poor, whose health benefits are covered by Medicaid.

"The people who are mostly going to be hurt by this are the 20 million who wouldn't have paid any surtax," said Representative Pete Stark, Democrat of California, the chairman of the Health Subcommittee of the Ways and Means Committee and a co-sponsor of the program. Mr. Stark said he did not believe the prospect of premium increases would cause Congress to preserve the program because those who would be hurt most were the least influential politically.

Premiums for Medigap policies range from about $500 to about $1,300 a year. The Blue Cross/Blue Shield Association estimates that repeal or cutback of the Medicare program to pay for major illness will increase monthly premiums in its policies by an average of 43 percent, or $21, in the North; 75 percent, or $14.24, in the West; 26 percent, or $12.38, in the East; 21 percent, or $11.40, in the South, and 13 percent, or $8, in the Midwest.

These increases would be in addition to increases that Blue Cross says would be to cover the cost of inflation in health care of 33 percent in the North; 14 percent in the West; 5 percent in the East and 10 percent in both the South and Midwest.

Raises Reported Less

Mr. Stark said, "These companies all told us this year that they raised their premiums less than they would have otherwise because the government's catastrophic coverage plan had taken over some of the exposure that their plans had covered."

The proposed rate increases for private insurance have stirred renewed controversy on Capitol Hill about the lobbying campaign waged by those who sought to repeal the surtax and ended up nearly destroying the program, which was passed with bipartisan support. The program pays for hospital costs above $560. Beginning Jan. 1 it would pay doctor bills of more than $1,370 and beginning in 1991 it would pay for half the cost of prescription drugs of more than $600.

The Health Insurance Association of America, which represents the health industry, estimates that supplemental insurance is held by more than 25 million people, or 78 percent of the 33 million Medicare beneficiaries, of whom 30 million are 65 and over and 3 million are disabled.

A vast majority of those with such insurance pay for it themselves. Three out of 10 older Americans receive some Medigap insurance as a retirement benefit, but many of them purchase additional Medigap insurance from private companies, according to the Employee Benefit Research Institute.

Albert A. Cardone, chairman and chief executive officer of Empire Blue Cross and Blue Shield, which covers New York City and suburbs, said, "If the Federal government covers less and we have to cover more, it would make sense to have a premium increase." He said that his organization would await final Congressional action on the program before applying for a rate increase.

In Massachusetts, Blue Cross/Blue Shield has applied for a 76 percent increase in the Medigap premiums, of which 43 percent is attributable to the repeal or drastic curtailment of the government program, said Alan P. Spielman, executive director of government relations of the Blue Cross/Blue Shield Association, which represents the Blue Cross/Blue Shield groups. He attributed the remaining 33 percent to both the inflation of health costs and the fact that the Medigap plan in Massachusetts had proved more costly than was expected.

Mr. Spielman said that in Cincinnati, Blue Cross/Blue Shield had applied for an increase of 22 percent, instead of 3 percent that otherwise would have been sought, while in California Blue Cross/Blue Shield applied for an increase of 26 percent above the cost of inflation.

Officials of the American Association of Retired Persons said that the policy that the organization offers through the Prudential Insurance Company will probably seek an increase 25 percent above inflation if the Medicare Catastrophic Coverage Act was repealed and 15 percent if the program is drastically curtailed.

Representative Brian J. Donnelly, Democrat of Massachusetts, and a sponsor of the House bill that would repeal the program, was asked about the rate increases sought by his home state and elsewhere, and said, "These are only rate requests."

"These companies always go to the high mark," Mr. Donnelly said.

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[illegible] of Warsaw, called [illegible] the [illegible] ever such agree- way in Eastern Europe."

Mass. Blues Seek 78% Rate Hike

By LORRAINE IANNELLO

Journal of Commerce Staff

Blue Cross and Blue Shield of Massachusetts is seeking a 78% rate increase for Medicare supplement coverage.

To blame is Congress' repeal of the Medicare Catastrophic Coverage Act of 1988, say company officials.

But Earl R. Pomeroy, president of the National Association of Insurance Commissioners, questioned the need for such an overwhelming rate hike.

State insurance regulators, testifying before Congress earlier this year predicted the likelihood of an avalanche of health insurance rate increase requests in the event the catastrophic coverage was repealed, said Mr. Pomeroy, who is North Dakota's insurance commissioner.

However, they anticipated hikes ranging from 8% to 30%, Mr. Pomeroy said.

"It sounds like a Cadillac coverage," Mr. Pomeroy said of the proposed plan by the Massachusetts Blues. "That's really expensive. We need to make sure those rates are actuarially justified."

Mr. Pomeroy said although he had not seen the details of the Massachusetts request, it appeared "to be well above what I expect to see in terms of increased premiums in light of the repeal of catastrophic." He said he did not think the benefits lost under catastrophic justify such an increase.

But Massachusetts Blues officials defended the rate request.

"Now that the federal government reneged on its commitment to maintain these benefits, the costs have been shifted to private insurance companies and Medicaid," said Karen Quigley, vice president in charge of health programs development.

The Blue Cross and Blue Shield supplemental program, known as Medex, provides coverage not included under Medicare, the federal health insurance program that covers people over age 65 and the disabled.

Medex has nearly 300,000 subscribers in Massachusetts. The new rates, proposed with an effective date of Jan. 1, would increase monthly premiums by anywhere from $58 to $76 depending on the type of coverage selected, Blue Cross officials said.

The most costly program, known as Medex 4, is new and would provide benefits for hospitalization, covered physician services and prescription drugs, Ms. Quigley said.

Chairman HEINZ. Let me welcome Bob Polilli—no stranger from Colonial Penn. Bob, please proceed.

STATEMENT OF ROBERT J. POLILLI, SENIOR VICE PRESIDENT AND CHIEF ACTUARY, COLONIAL PENN INSURANCE CO.

Mr. POLILLI. I'm a senior vice-president and chief actuary in Colonial Penn. Alexis Berg is beside me here. She's the associate general counsel, and I'll try to be brief here.

Colonial Penn has been a pioneer in providing life and health insurance to people age 50 and older since the 1950's, and today Colonial Penn insures more than 220,000 health insurance customers over age 50.

I'd like to describe the package of benefits we currently offer. We agree fundamentally Medicare is complicated. As a matter of Federal and State law Medicare supplement insurance dovetails into the benefits provided by Medicare.

We do feel we do an excellent job in explaining the relatively complicated product through our marketing materials and through the outlines of coverage that are given to the consumer at the point of sale. A copy of a typical outline is attached to my written testimony.

The outlines are particularly useful in comparing competing products, since the format is mandated by the NAIC and will be the same for all Medicare supplement products. Colonial Penn offers a portfolio of Medicare supplements, and this provides the flexibility to choose coverage that suits each individual's needs.

Today Colonial Penn offers a choice of four plans with increasing benefit levels as well as two optional riders. We use a building block approach with these plans. We use the minimum standards as the basic building block of a product series, which permits important benefits to be added, again, depending on the circumstances of the insured.

Our experience with the older consumer has helped us design the kind of portfolio products we believe best meets the need of the customer group. We found out in general the older consumer has time to carefully review insurance literature, and intelligence to make informed decisions when purchasing insurance policies.

I'll now describe the process by which we determine the need for rate increases. First, we want to distinguish between rate increases where a premium is charged for an additional benefit and rate increases where a premium increases for an existing benefit because of inflation pressures. Only the latter we would call a rate increase.

With the repeal of the Medicare Catastrophic Act of 1988, certain benefits must be added to the new Medicare supplement policies sold. These benefits are added effective January 1, 1990; thus a great deal of premium will be increased because of the mandatory added benefits. We have attached to the written testimony five charts that illustrate the premium increases we expect in 1990.

On our written testimony in chart 1, we illustrate the premium increases for the average cost area in Pennsylvania for an insured at age 65 to 69, due to an increase in benefits. These increases are effective January 1, 1990. All four plans on chart 1 will have premium increase of $95 a year or $7.92 a month to provide the additional benefits.

Chart 3 shows the dollar figures for the monthly premium increases in a low cost area as well as a high cost area, and for other issue ages. The premium increases range from $6.67 a month to $16.25 a month. Again, these increases are for the increased benefits.

The inflationary component of the 1990 premiums is reflected primarily in plans 3 and 4, which provide a benefit for excess Medicare charges under Part B. These are shown in charts 2 and 5 and these increases which will come later in the year, vary from 91 cents a month to $1.83 a month.

We were also asked specifically to comment on the review of premium increases by the Insurance Commission. Colonial Penn files rates and forms in each State and waits for that State's approval before a policy is issued in that State.

We find most States review rates and forms very closely, especially for Medicare supplements which are such a prominent consumer concern. We found the review of Medicare supplement rates to be thorough. In addition to the rate filings necessary, whenever a new product is developed or a rate increase is needed, we are required annually to provide each State with a Medicare supplement experience exhibit that shows the loss ratio for each form in each State.

In this way States have the information to enforce their loss ratio requirements. In summary we are proud of our history of serving the insurance needs of older Americans. We are confident that our portfolio approach to benefit building is responsive to the needs of our customer group and we believe that our 1990 premium increases are reasonable in view of the added benefits and inflationary pressures.

Chairman HEINZ. Thank you very much.

Let me just clarify one thing you said, where you listed the so-called added benefits—those which result in the cost increase of $7.92 a month—those are essentially, as I understand it, all benefits that you have to pick up as a result of the repeal of Medicare catastrophic; is that correct?

Mr. POLILLI. That's right, exactly.

Chairman HEINZ. So the cost of the repeal and increase in your policy is $7.92 a month?

Mr. POLILLI. Yes, that's for age 65 to 69 and average age for the base policy there's some variation by plan and by cost area.

[The prepared statement of Mr. Polilli follows:]

Colonial Penn Group, Inc.

Robert Polilli
Senior Vice President
and Chief Actuary

Direct Dial
215-988-3699

January 5, 1990

The Honorable John Heinz
United States Senate
Special Committee on Aging
Washington, DC 20510-6400

Dear Senator Heinz and Members of the Special Committee on Aging:

I am Robert Polilli, Senior Vice President and Chief Actuary of the Colonial Penn Group, Inc. Colonial Penn is a pioneer in providing life and health insurance to people age 50 and older. We have had more than 25 years of experience in serving the needs of older Americans. In the 1950's, before there was a Medicare program, when Americans reaching retirement age often found health insurance difficult to obtain, we were instrumental in obtaining the first nationwide guaranteed issue group health insurance program. Today, Colonial Penn insures more than 220,000 health insurance customers over age 50 through both direct response marketing and agency sales.

Senator Heinz has requested Colonial Penn to address certain concerns of the Committee regarding Medicare supplement insurance.

In particular, we are asked to address 1) the variety of benefit packages from which retirees must choose, (2) the process by which premium increases are calculated, and (3) how premium increases are reviewed by the Insurance Commission.

I'd like to start by briefly describing the packages of benefits offered by Colonial Penn. Fundamentally, Medicare is complicated. As a matter of Federal and State law, Medicare supplement insurance dovetails into the benefits provided by Medicare. We feel that we do an excellent job of explaining a relatively complicated product through our marketing materials and the Outlines of Coverage that are given to the consumer at the point of sale. A copy of a typical Outline is attached to my testimony. The Outlines are particularly useful in comparing competing products, since the format is mandated by the NAIC and will be the same for all Medicare supplement products. Additionally, our 25 years of experience in dealing with Americans over 50 have demonstrated that as consumers, our customers are intelligent, well-informed and capable of selecting the coverage that best meets their needs.

Colonial Penn offers a portfolio of Medicare supplements. This provides the flexibility to choose coverage that suits a person's particular needs.

Colonial Penn today offers in most states, through its agency operations, a choice of four plans with increasing benefit levels as well as two optional riders. Through direct response sales we offer two products that are essentially the same as plans One and Two in the agency portfolio. We utilize a building block approach with these plans.

The basic policy, Plan One, provides the Minimum Standards for Medicare supplement insurance in each state and includes several low-cost ancillary benefits such as Skilled Nursing Facility coinsurance.

Plans 2, 3 and 4 provide increased benefits as follows:

> Plan 2 provides the benefits of Plan 1 and it also covers Medicare's $75 Part B medical deductible;
>
> Plan 3 provides the benefits of Plan 2 and it also covers excess Part B medical costs with a $200 deductible;
>
> Plan 4 provides the benefits of Plan 3 removing the $200 deductible for excess medical charges.

The two optional riders available with all four plans cover the Part A Hospital Deductible and benefits for Home Health Care.

Thus, we use the Minimum Standards as the basic building block of a product series which permits important benefits to be added depending on the circumstances of the applicant. For example, those insureds who only feel confident with full coverage without deductibles elect Plan 4 with the riders for the Part A Deductible and Home Health Care. And other insureds, on a tighter budget, may choose the basic benefits provided by Plan 1 with no optional riders at all.

Colonial Penn's experience with the older consumer has helped us to design the kind of portfolio of products that we believe best meets the needs of our customer group. We have found that, in general, the older consumer has time to carefully review insurance literature and the intelligence to make informed decisions when purchasing an insurance policy.

I will now describe the process by which we determine the need for rate increases. First, it is important to distinguish between the premium charged for an additional benefit and a premium increase for an existing benefit because of inflationary pressures. Only the latter is appropriately characterized as a "rate increase."

With the repeal of the Medicare Catastrophic Coverage Act of 1988 certain benefits must be added to the new Medicare supplement policies sold, effective January 1, 1990.

The added benefits are:

Part A initial deductible revision to "benefit period" and increase
from $560 to $592
Coinsurance for Part A hospital days 61 to 90
Coinsurance or actual cost for Part A hospital days 91+
Revised Skilled Nursing Facility benefits
20% of Part B costs in excess of 1990 cap that was removed
by the repeal of the Catastrophic Coverage Act

The premiums will increase because of these mandatory added benefits; 1990 premiums will also reflect inflationary increases in the cost of existing benefits.

We have attached to our testimony 5 charts that illustrate the premium increases we expect in 1990 both because of the additional benefits and because of the effects of inflation on existing benefits. To understand the charts, you should also be aware that Colonial Penn uses an area-rating system under which we have 5 different rate areas, depending on the cost of providing insurance benefits in that particular area. We also vary rates by issue age. The area rating system enables Colonial Penn to price our policies with sensitivity to the actual cost of health benefits provided to the insured in that geographic area.

Chart 1 illustrates the premium increase expected in an average cost area in Pennsylvania for an insured age 65 to 69 due to the increase in benefits. These increases are effective January 1, 1990, the effective date of the added benefits, in states in which we do business. On Chart 1, all 4 plans will increase by $95 a year or $7.92 a month to provide the additional benefits. The percentage increase varies from 13% to 23% depending on the cost of the underlying plan. Chart 3 shows the dollar figures for the monthly premium increases expected in a low cost area and a high cost area and for other issue ages. The premium increases range from $6.67 to $16.25 monthly. Actuarially, these are not technically rate increases; they show the cost of insurance for the additional benefits provided.

The inflationary component of the 1990 premiums is reflected primarily in Plans 3 and 4 which provide a benefit for the Part B excess medical charges. Charts 2 and 5 illustrate actual rate increases for which we intend to file for approval later in the year.

I've been speaking primarily about new sales. Now let's turn to inforce policies. These plans are not identical to our current plans. The supplemental insurance benefits eliminated in these policies by the Catastrophic Coverage Act in 1989 were restored by the repeal of the Act in 1990. Since benefits will be added, additional premium will be required. Chart 4 shows the increases attributable to the additional benefits for policies issued in 1985-1988. Other inforce policies will experience similar increases. I'd like to specifically point out that the premium on these inforce policies actually did go down on January 1, 1989 because of the reduction in benefits. The 1989 decrease was similar to the 1990 increase that we have explained.

We were also specifically asked to comment on the review of premium increases by the Insurance Commission. Colonial Penn files rates and forms in each state and waits for that state's approval, before a policy is issued in that state. Current circumstances are somewhat exceptional. Because the Catastrophic Coverage Act was repealed in late November and new benefits were required as of January 1, some states have permitted an expedited filing procedure. Most states review rates and forms very closely, especially for Medicare supplements which are such a prominent consumer concern. We have found the review of Medicare supplement rates to be thorough.

One of the things that the states look at in rate filings is the ratio of benefits payable to premium. This is calculated on a block of business and is called the loss ratio. Individual Medicare supplement insurance is required by law to have a loss ratio of at least 60% in Pennsylvania.

The loss ratio does not include any of the expenses of the insurance company except for benefits paid. To draw an analogy with a manufacturing company, the benefits paid are the raw materials an insurance company has to build a product. In order for the product to reach the consumer, it must be designed, manufactured, sold, and then administered after the sale. None of these costs are included in the loss ratio. The cost of raw materials as a percent of the cost of the final product varies from industry to industry, but the Medicare supplement insurance industry compares very favorably.

In addition to the rate filings necessary whenever a new product is developed, or a rate increase is needed, we are required annually to provide each state with a Medicare supplement experience exhibit that shows the loss ratio for each form and for each state. In this way, states have the information to enforce their loss ratio requirements.

We are proud of our history of serving the insurance needs of older Americans. We're confident that our portfolio approach to benefit building is responsive to the needs of our customer group. We believe that our 1990 premium increases are reasonable in view of the added benefits and inflationary pressures.

I trust that our testimony has been responsive to your questions and concerns, and I thank you again for the opportunity to present Colonial Penn's perspective on an issue as important to our senior citizens as Medicare supplement insurance.

Respectfully submitted,

Robert J Polilli

Robert J. Polilli, FSA, MAAA

Senior Vice President and Chief Actuary

RJP:jam
Attachments
1848J

CHART 1

COLONIAL PENN MEDICARE SUPPLEMENT POLICIES

ISSUED 1989 - PRESENT

PENNSYLVANIA   AGES 65 - 69   AVERAGE COST AREA

	1989 ANNUAL PREMIUM	1990 ANNUAL PREMIUM	INCREASE ANNUAL PREMIUM	INCREASE MONTHLY PREMIUM	PERCENT INCREASE
PLAN 1	$415	$510	$95	$7.92	23%
PLAN 2	$485	$580	$95	$7.92	20%
PLAN 3	$590	$685	$95	$7.92	16%
PLAN 4	$755	$850	$95	$7.92	13%
RIDER A (PART A DEDUCTIBLE)	$205	$235	$30	$2.50	15%
RIDER B (HOME HEALTH CARE)	$195	$195	$ 0	$0.00	0%

CHART 2

COLONIAL PENN MEDICARE SUPPLEMENT POLICIES

ISSUED 1989 - PRESENT

SUBSEQUENT 1990 PREMIUM INCREASES

PENNSYLVANIA AGES 65 - 69 AVERAGE COST AREA

	INITIAL 1990 ANNUAL PREMIUM	SUBSEQUENT 1990 ANNUAL PREMIUM	SUBSEQUENT INCREASE ANNUAL PREMIUM	SUBSEQUENT INCREASE MONTHLY PREMIUM	SUBSEQUENT PERCENT INCREASE
PLAN 3	$685	$696	$11	$.91	2%
PLAN 4	$850	$877	$27	$2.25	3%

CHART 3

COLONIAL PENN MEDICARE SUPPLEMENT POLICIES

ISSUED 1989 - PRESENT

RANGE OF MONTHLY PREMIUM INCREASES

ALL PLANS

AGES	LOW COST AREA	AVERAGE COST AREA	HIGH COST AREA
65 - 69	$6.67	$7.92	$12.50
70 - 74	$7.50	$8.75	$13.75
75 - 79	$7.92	$9.58	$15.00
80 +	$8.75	$10.42	$16.25

CHART 4

COLONIAL PENN MEDICARE SUPPLEMENT POLICIES

Issues of 1985 - 1988

JANUARY 1, 1990, Premium Increases

Pennsylvania   Ages 65 - 69

	1989 Annual Premium	1990 Annual Premium	Increase Annual Premium	Increase Monthly Premium	Percent Increase
Plan 1	N/A	N/A	N/A	N/A	N/A
Plan 2	$678	$834	$156	$13.00	23%
Plan 3	$797	$953	$156	$13.00	20%
Plan 4	$1,094	$1,250	$156	$13.00	14%

CHART 5

COLONIAL PENN MEDICARE SUPPLEMENT POLICIES

1990 Subsequent Premium Increases

Pennsylvania   Ages 65 - 69   Average Cost Area

Policies Issued   1985 through 1988

	Initial 1990 Annual Premium	Subsequent 1990 Annual Premium	Subsequent Increase Annual Premium	Subsequent Increase Monthly Premium	Subsequent Percent Increase
Plan 3	$953	$965	$12	$1.00	1%
Plan 4	$1,250	$1,284	$34	$2.83	3%

MSP 3 ☐

MSP 4 ☐

Colonial Penn Life Insurance Company
Colonial Penn Plaza/ 19th & Market Sts Philadelphia. Pennsylvania 19181

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE AND PREMIUM INFORMATION

Use this outline to compare benefits and premiums among policies.

1 Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2 Medicare Supplement Coverage — Policies of this category are designed to supplement Medicare by covering some hospital. medical and surgical services which are partially covered by Medicare Coverage is provided for hospital inpatient charges and some physician charges. subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare. and subject to other limitations which may be set forth in the policy The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine

3 Neither Colonial Penn Life Insurance Company nor its agents are connected with Medicare

DESCRIPTION/SERVICE	THE POLICY PAYS	YOU PAY
I. Minimum Standards **PART A** INPATIENT HOSPITAL SERVICES Semi-Private Room & Board, Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests and Operating Room In any one Medicare Benefit Period		
Days 61 through 90	$148 a day (the Medicare coinsurance)	Nothing
Days 91 through 150	$296 a day (the Medicare coinsurance)	Nothing
Days 151 and after	100% of your expenses for room and board and necessary services for up to a lifetime maximum of 365 days	Nothing for up to 365 days; then 100% of costs
BLOOD	Your expenses for the Part A blood deductible	Nothing
PART B MEDICAL EXPENSE Services of a Physician/Outpatient Services, Medical Supplies other than Prescribed Drugs	Medicare coinsurance amounts (20% of Medicare allowable charges)	Any expenses not paid by Medicare or the policy
BLOOD	Your expenses for the Part B blood deductible	Nothing
MISCELLANEOUS Immunosuppressive Drugs In the first year following an organ transplant covered by Medicare	The benefits shown above for MEDICAL EXPENSE	Same as MEDICAL EXPENSE
II. Additional Benefits **PART A** PART A DEDUCTIBLE (Optional Benefit) ☐ If you elect this optional benefit, your agent will check this box. If this box is checked, your benefits are: For days 1 through 60 in any one Medicare Benefit Period	$592 (the Medicare hospital deductible)	Nothing
PRIVATE ROOMS In-hospital private room and board beyond what is covered by Medicare	100% of the difference between the hospital's most prevalent private room and board rate and the hospital's most prevalent semi-private room and board rate at the time of your admission	Nothing
IN-HOSPITAL PRIVATE NURSES In-hospital private duty nursing	$60 per shift for Registered Nurse or Licensed Practical Nurse care; maximum of 3 shifts per day; 50 shifts for all private duty care during any one calendar year	Any expenses not paid by the policy

(continued)

DESCRIPTION/SERVICE	THE POLICY PAYS	YOU PAY
SKILLED NURSING FACILITY CARE In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge In any one Medicare Benefit Period		
Days 1 through 20	No Coverage	Any expenses not paid by Medicare
Days 21 through 100	$74 a day (the Medicare coinsurance)	Any expenses not paid by Medicare or the policy
Days 101 and after for up to 200 additional days	Your actual charges per day up to the daily Medicare coinsurance amount in effect on the 100th day of your confinement. Lifetime maximum $100,000	Any expenses not paid by the policy
PARTS A & B HOME HEALTH CARE (Optional Benefit) ☐ If you elect this optional benefit, your agent will check this box. If this box is checked, your benefits are		
Home Health Services	$30 per visit, limited to one visit per day, up to 90 visits per calendar year for ages 65-74, up to 30 visits per calendar year for ages 75 and over	Any expenses not paid by Medicare or the policy
PART B PART B DEDUCTIBLE	The $75 Part B calendar year deductible	Nothing
MEDICAL CHARGES IN EXCESS OF MEDICARE ALLOWABLE EXPENSES (PERCENTAGE PAID)	100% of all covered excess expenses, after a $200 calendar year excess expense deductible (MSP3) or 100% of all covered excess expenses (MSP4) depending on which Plan you elect Note: Covered excess expenses = the difference between the Medicare allowable charge and the amount actually billed to Medicare by the provider Your agent will check the appropriate box on the first page of this outline	The $200 calendar year excess expense deductible (MSP3) or Nothing, there is no excess expense deductible (MSP4)
OUT-OF-POCKET MAXIMUM	The policy does not have an out of pocket maximum	Any expenses not paid by Medicare or the policy
PRESCRIPTION DRUGS (outpatient)	No Coverage	All costs
MISCELLANEOUS Respite Care Benefits	No Coverage	Any expenses not paid by Medicare
Expenses incurred in a foreign country (if not covered by Medicare)	No Coverage	All costs
Other Ambulance Service	$50 per trip to a hospital	Any expenses not paid by Medicare or the policy

(continued)

IN ADDITION TO THIS OUTLINE OF COVERAGE, COLONIAL PENN WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

5. The policy does not cover the following:

a. Custodial nursing facility care costs

b. Intermediate nursing facility care costs

c. Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, costs of eyeglasses or hearing aids or of examinations therefor

6. Exclusions/Limitations

Pre-Existing Conditions: Confinements, care and services which are due to pre-existing conditions are not covered during the 3-month period after the date the policy takes effect. A pre-existing condition is an injury or sickness for which you receive medical advice or treatment during the 3-month period prior to the date the policy takes effect.

War: Injury or sickness caused by or resulting from any act of war following the effective date of the policy (whether the war is declared or undeclared) is not covered.

The chart summarizing the Medicare benefits only briefly describes such benefits. You should consult the Health Care Financing Administration or its Medicare publications for further details and limitations.

7. Renewability/Rate Changes

Subject to all the provisions of the policy, your policy is guaranteed renewable by timely payment of the premium due.

Your premium is based on your age and rating area on the effective date of your policy. It can change if you move your permanent residence to a different rating area. In addition, the premium rate can change if Colonial Penn changes the premium rate for all persons in your class insured under policy form series 4-82-595 (Rev).

8. The amount of premium for the policy is $____________________

You have elected payments of $______________ every ______________ month(s).

If you and your spouse apply at the same time and you are both approved, your premiums will be reduced by 10%.

Chairman HEINZ. Let me return to Gene Ott, of the Blue Cross. Gene, as you know, testified that on average Medicare costs are going to increase about 20 percent. Yet, as I understand it, Independence Blue Cross has requested a 58 percent increase.

Can you explain why such a large increase is necessary in a way that a layman like myself can understand it?

Mr. OTT. OK, Senator, the rate increase really is 51 percent, the 58 percent is for a very limited policy that we have, it's not a Medigap supplemental policy.

Basically what happened is that in 1988 our approved rates were $28.40 which were approved by the Insurance Department and reviewed. Subsequently when the catastrophic program came into effect, we reduced our premiums almost 19 percent, and that moved our rate down to $23.05.

With the repeal of the catastrophic, with the increase in the deductibles and the co-payments, the inflation that's involved, with increased utilization because of our people that are getting older and with the repeal of catastrophic, there was a need for us to increase the rates to the level of $35.

When you look at the rate from 1988, the $28.40 to $35, that increase is really 11.4 percent a year. So, that the percentage is not as high as it may appear when you say 51 percent, it certainly does seem high, but when you look at what has happened in the past and also, as you just heard, we do not age rate.

So that a lot of our subscribers are older, we have people that are under 65 that use more health care than other insurers that won't insure people under 65. So these additional claims that we've been seeing, even though our subscriber rate has been going down, has contributed to the increased cost.

Chairman HEINZ. I can understand that.

Mr. OTT. Thank you.

Chairman HEINZ. That's very good, thank you very much.

Mr. Rooney, now, as you mentioned, you're very active in the selling of life insurance and although you are inactive in selling it through Pennsylvania, through no fault of your own, I gather, as you described it, I'm sure somebody from the Pennsylvania Insurance Commissioner's office received that message.

Mr. ROONEY. We hope so.

Chairman HEINZ. Yes, I figured you'd like that received. Let me ask you about one thing, this is a letter signed by you, I believe, which forcefully advocates the repeal of catastrophic coverage.

Now, it's a free country and people should be at liberty to take any point of view they want. But since you're also in the business of selling Medigap insurance and since the repeal of catastrophic coverage creates a bigger gap and since people price their policies on a percentage, does it not strike you as a conflict of interest to advocate repeal of something that closes the gap so that it can be made wider so that you can have more business opportunity?

Mr. ROONEY. No it doesn't, because, you know, we're in the business of providing for our customers savings, and trying to advocate to our customers the best utilization of their money, and, clearly, I believe the Catastrophic Care Act was not the best utilization of their money. I'm about to be one of those seniors, but—at any rate.

Chairman HEINZ. Let me ask you, on that point, let me ask you, when we had our first panel, our panel of expert witnesses from GAO, the Pennsylvania Insurance Commissioner, and the Pennsylvania Cost Containment Council, they were unanimous in stating that in terms of value, the Medicare catastrophic coverage program that Congress had provided was superior—because it had lower administrative costs, lower selling costs, it was more efficient in delivering a bang for the buck, if you will, than even the Blues, which are nonprofit.

And what is your justification for saying that your approach is in effect a better value?

Mr. ROONEY. First of all, you shouldn't say that, first of all, it's a better value. Medicare, before it was amended by catastrophic care, was already catastrophic coverage, it provided after the initial deductible essentially 100 percent coverage for 60 days in the hospital and with a co-payment, the person had coverage for a total of 150 days.

Now, whether we, as a society, should make it a matter of public policy to tax some seniors to create a benefit that would extend that for 365 days for everybody is very questionable to me.

I am about to sign, it's now been delivered to my desk, a living will, to prevent that kind of extended care to me. I don't want to be artificially kept alive just because it can be done. As I see catastrophic care, I think it was more catastrophic care for the hospitals than it was for the seniors.

But if a senior wishes to voluntarily, on his or her own money, pay for that kind of extended care, maybe that's all right for them to do, but whether we, as a society, should impose that on all seniors, is very questionable to me.

Our greater problem with Medicare care, of course, is the issue of long-term care for seniors. Now, there indeed is a big problem for seniors, which was not helped by catastrophic care at all.

Chairman HEINZ. Let me ask you this: Let's suppose that I've been a policyholder of yours or some other company since 1980 and that in 1986 I got cancer, liver carcinoma, to be specific. It's a very rare cancer, only seven people in the country have ever had it, and I needed some radiation or chemotherapy. I needed some medication to enhance my liver function.

When I joined up with, in this case, hypothetically your company or a company like yours, I was paying roughly $100 a month, kept my premiums current, and that over the last 4 years my premiums have, because I had an operation, because I needed some chemotherapy, my premiums have increased from, in 1986, maybe a couple hundred a month to now $850 a month for 1990.

I can't afford that, I can't afford that, if I'm just working, if I'm just an ordinary guy, what's my recourse against those kind of increases?

Mr. ROONEY. Are you talking about a senior citizen?

Chairman HEINZ. No.

Mr. ROONEY. Either the $100 a month or $850.

Chairman HEINZ. No. I'm not talking about a senior citizen, I'm talking about just a guy, I might be 65 but I'm still working.

Mr. ROONEY. Well——

Chairman HEINZ. Can somebody actually do that to me, can someone increase my premiums that way?

Mr. ROONEY. I believe major medical insurance for the younger people, the people under 65, has gotten terribly expensive, that's correct.

Chairman HEINZ. $850 a month, that's $10,000 a year.

Mr. ROONEY. I believe it, sure, the Federal employees that——

Chairman HEINZ. For one person, not family. Individual.

Mr. ROONEY. I don't know, I don't know. But the Federal employees who have Blue Cross are paying that kind of premium, the kind of premium you're talking about, so, yes, that's possible.

Chairman HEINZ. Let me get back, that was a hypothetical case that really had nothing to to with you, you obviously sell in a lot of States, I was curious about your answer to that. It happened to be a true case, it didn't happen to me, it happened to someone I know.

You mentioned that your company is rated the best buy by Consumer Reports, indeed, it is. Your marketing executive, Susan Puroro, says that one of the reasons you are able to keep your prices low is that you keep your costs down by rejecting 20 to 30 percent of applicants who are 65 and as many as 50 percent of those who are 70. She says we look for the healthy risk. Is that accurate?

Mr. ROONEY. Yes. We are not an insurer of last resort, I think those numbers may be a little on the high side, but I'll accept that.

Chairman HEINZ. My understanding is that you've been critical of such organizations as Massachusetts Blue Cross, which asked for a 75-percent increase in insurance premium.

Mr. ROONEY. I don't know that we've been critical of any particular Blue Cross, except to say that you can't justify a 75-percent increase, nor can you justify a 40-percent increase on account of the repeal of catastrophic care.

The insurance company may have deficient premiums, but in that case the premiums were probably deficient before catastrophic are came along.

Chairman HEINZ. You heard Mr. Ott's explanation, he's got a 51-percent increase.

Mr. ROONEY. Yes I did hear.

Chairman HEINZ. Is his increase justified?

Mr. ROONEY. It may be, but it's not because of repeal of catastrophic care.

Chairman HEINZ. As I understand his numbers, most of it is, first he dropped his premiums when some of those costs were removed and then had to increase them and he spelled it out in some detail, the $7.92.

Mr. ROONEY. I did hear the things also, I think he said he had dropped his premium 19 percent, because of the repeal of catastrophic care.

Chairman HEINZ. That's right.

Mr. ROONEY. You know that we dropped our premium 5 percent because on our basic policy——

Chairman HEINZ. I am not questioning what you did. I'm just trying to understand if you believe his increase was justified. You're State Insurance Commissioner for the day, you're in the role of the State Insurance Commissioner looking at his rate increases.

Mr. ROONEY. His rate increase may be necessary, but that magnitude of rate increase is not necessary because of repeal of catastrophic care.

It may be that his premiums are deficient and, of course, companies have—it has been politically popular, as it was last year, to give big rate decreases that they may not have been able to justify in the long run.

Chairman HEINZ. I want to correct my testimony. It was Bob Polilli who was talking about the $7.92. Strike that part from the testimony. I was referring to the earlier explanation.

Let me ask Bob, at this point. What was your total percentage increase, did you say? Let's say for three or four?

Mr. POLILLI. For our average cost area and our most popular plan, it was 16 percent.

Chairman HEINZ. Most of that was accounted for by the $7.92?

Mr. POLILLI. Yes, that's what the 16 percent is.

Chairman HEINZ. Does that appear reasonable to you, Mr. Rooney, $7.92, as a result of the repeal of catastrophic?

Mr. ROONEY. It's certainly—was the $7.92 only due to the repeal of catastrophic care?

Chairman HEINZ. Yes.

Mr. POLILLI. Right.

Mr. ROONEY. Or was part of the $7.92 due to the increase in the deductible, that was not clear to me.

Chairman HEINZ. The increase in the hospital deductible from $560 to $592.

Mr. ROONEY. Right. Is part of the $7.92 due to that?

Mr. POLILLI. It is.

Chairman HEINZ. Yes, it is, that would have taken place even if catastrophic hadn't been repealed.

Mr. ROONEY. That's right, it sure would have. So of that $7.92 a good piece of that increase would have happened independently of the repeal of catastrophic care, only part of that is due to catastrophic care.

Chairman HEINZ. Bob, do you have any numbers on the extent of which that change in the Part A deductible affects what piece of the $7.92, that is?

Mr. POLILLI. I'm sorry, the Part A deductible is a rider.

Chairman HEINZ. Beg your pardon?

Mr. POLILLI. The Part A deductible is provided by a rider, so the $7.92 covers those increased benefits for the base plan. The effect of increased benefits of the Part A deductible rider is an additional $2.50 premium if you had that rider.

Chairman HEINZ. So this $7.92 doesn't include that change?

Mr. POLILLI. Correct; if you had our basic plan with the Part A rider total the increase would have been $10.42.

Chairman HEINZ. So you're comparing apples to apples.

Mr. OTT. Senator, it's important to point out that at least in our numbers that are being questioned here today, the figures that we talk about are gross in terms of all the benefits being included in that one figure. We have not age rated, we have not area rated, we have not added riders for deductibles or co-pay, all the figures are inclusive.

And the total only comes to an increase of $11.95, if you put it by the percentages, at least I'd like that for the record.

Chairman HEINZ. What is your, I guess the right term is loss ratio?

Mr. OTT. I have them right here.

Chairman HEINZ. Roughly.

Mr. OTT. For 1979, if I may I'll just go through them with you.

Chairman HEINZ. Just roughly.

Mr. OTT. It's over 100 percent.

Chairman HEINZ. It's over 100 percent?

Mr. OTT. We pay more than a dollar for every dollar we take in.

Chairman HEINZ. It's amazing you're still in business.

Mr. OTT. Let me explain why, our group business, which we have to compete with other insurers on a group marketplace, subsidizes our nongroup business, so this past year we took $8 million from our group accounts to subsidize our individual as well as our over 65 and under 65 Medicare supplement. If you took away that $8.1 million subsidy we would really be in trouble.

Chairman HEINZ. Mr. Rooney, roughly what is your loss ratio?

Mr. ROONEY. That varies, I did hear you say a moment ago, this gentleman on my right, Pennsylvania mandates a minimum loss ratio of 60 percent, I believe ours is above that.

Chairman HEINZ. But close to it.

Mr. ROONEY. Probably so.

Chairman HEINZ. Bob, what about you, what about Colonial Penn?

Mr. POLILLI. We are targeting for 60 percent loss ratio. In the first policy year, we do have underwriting, so the loss ratio tends to run lower, but over the life of each policy we expect to be at 60 percent and we are on track for that.

Chairman HEINZ. I think all have been extremely helpful and candid and given us a very good base of information and statistics on which to try to understand this issue better.

I want to thank each of you for having participated, for the preparation that you went to, for your excellent answers, and for the very interesting discussion I think that we had between a Blue, a not-for-profit in Pennsylvania, which is to say a for-profit in every place else, he doesn't sell here, and from the Colonial Penn Co., which many of us know very well, although I am not currently insured there. And to Senator John Hopper, John, if you have any questions, feel free, I have got to catch a plane. Since this is State Senate property, I'm going to leave it to you to close the hearing.

Senator HOPPER. I just have one quick question for Mr. Rooney. You said you submitted your rates in 1989 and they weren't acted upon until November 1989 by the Insurance Commission for the Department.

Mr. ROONEY. Actually the rate——

Senator HOPPER. Did they have a reason for that, what reasons did they give?

Mr. ROONEY. I don't know, I tell you it is a pattern of behavior for the Pennsylvania Insurance Department.

At the beginning of 1989, I said let's give up, let's quit fighting unless we're going to do a ton of business in Pennsylvania, we can't justify the cost of having special lawyers and special actuaries to fight with Pennsylvania.

But, of course, one of the benefits to the marketplace is that our very attractive policy, which will have an impact on everybody else, when it's best buy by Consumer Reports, it isn't in the marketplace in Pennsylvania, and that's one of the consequences with that kind of regulation.

Years ago there was a story in connection with voting rights, when this well educated black person in Alabama was supposed to have gone to register to vote and he was asked a bunch of questions about the Constitution and asked what they meant. And his response was, it means I'm not going to be able to vote in Alabama.

Our experience with Pennsylvania is that the litany of questions only mean that they'd like it if this product was not available in Pennsylvania.

Senator HOPPER. Thank you. Is your policy selective, do you have the right to refuse coverage?

Mr. ROONEY. Yes, I thought that was clear.

Senator HOPPER. Whereas the Independence Blue Cross will take everybody.

Mr. ROONEY. That's right. That is what he said and I believe that's correct. Of course, that situation—there is room for both and that situation justifies a higher premium, I believe it does.

Senator HOPPER. Right. And the Independence Blue Cross, I imagine, has communication with Capital Blue Cross in the area; is that right?

Mr. OTT. Yes, we do, obviously we're independent corporations but we do have a lot of liaison and we do discuss issues with each other.

Senator HOPPER. Do you have similar experience?

Mr. OTT. Yes.

Senator HOPPER. The central Pennsylvania area is the same in the counties you cover in southeastern Pennsylvania?

Mr. OTT. I would suspect our people are probably a little older than the Capital Blue Cross people. I can't tell you that for a fact, but I think that's true, so they would use more health care, they have more admissions to the hospital than the Capital Blue Cross folks may have.

Senator HOPPER. Bob Polilli, Colonial Penn does a lot of advertising on television. I'm wondering if the life experience has an affect on your Medicare supplement rates, since you're the chief actuary?

Mr. POLILLI. If our life experience?

Senator HOPPER. Yes, as advertised on television, shouldn't you sign now, anybody from 50 to 80?

Mr. POLILLI. Of course, if someone has signed up for a life insurance, we see that they know about our Medicare supplement insurance when they're eligible at age 65. Our life insurance goes down at age 50, so, they are customers of ours then and we offer them Medicare supplement when they turn 65. That's true.

Senator HOPPER. My question was, does it effect the Medicare supplement rates, the experience of the life side?

Mr. POLILLI. Not directly. I mean we're trying to have equitable rates for both sides that are self-supporting, so that they don't effect each other.

Senator HOPPER. I don't have any further questions unless you gentlemen have any comment or questions.

Then this meeting stands adjourned. Thank you much for coming.

[The hearing was concluded at 12:25 p.m.]

APPENDIX

Item 1

U.S. SENATE AGING COMMITTEE
STATEMENT OF SENATOR LARRY PRESSLER
HEARING ON MEDICARE SUPPLEMENTAL HEALTH INSURANCE
JANUARY 8, 1990

I commend my colleague and friend, Senator Heinz, for chairing this hearing on rising premiums for Medicare supplemental health insurance (Medigap). The dramatic increase in private Medigap premiums is a serious matter. These rate hikes deserve a thorough investigation.

Premium increases are a serious matter for all senior citizens, but especially for those on fixed incomes. Many older Americans simply cannot afford a seven to twelve percent premium increase. America's older citizens received only a 4.7 percent cost-of-living adjustment (COLA) in 1990. Yet their supplemental insurance premiums have gone up by at least seven percent. How can they afford such an increase as well as the higher cost of food, utilities, housing and other necessities? Many senior citizens on fixed incomes will be forced to dip into their modest savings, if they have any, to pay for these increases in their cost of living.

Insurance companies are laying the blame for the premium increase on the 1989 repeal of the Medicare Catastrophic Coverage Act. In fact, long before that repeal occurred, which I opposed, insurance companies were warning senior citizens that their premiums would skyrocket if the catastrophic program were repealed. I cannot believe that elimination of the catastrophic program is the principal reason for increasing insurance premiums. I hope this hearing will help determine whether insurance companies are using repeal of the catastrophic program as a scapegoat to justify their actions.

Insurance rates would have gone up even if the catastrophic program had remained intact. Why? Health-care costs rose once again in 1989. That seems to be the primary culprit for this Medigap rate increase. Insurance policies operate as a form of socialized protection. Subscribers pay premiums to a company which in turn pays their bills. Insurance is like a credit card. Eventually the policyholders must pay the bill.

A negative side of this kind of insurance is that subscribers are sheltered from realizing the full impact of health-care costs. One may have a policy that directly pays the hospital or doctor. In this situation, the policyholder may not be fully aware of the effect of rising health-care costs.

It is time for insurance companies to provide a detailed explanation to seniors of why their premiums will increase. Companies should be accountable to their policyholders. Laying the blame on repeal of the catastrophic program is an excuse, It is no substitute for an honest explanation for health insurance rate increases.

As a member of the Senate Aging Committee, I add my support to a thorough review of supplemental health insurance premiums. The senior citizens of America are victimized to the extent they are not told the whole story.

Senator Heinz, thank you for this opportunity to speak out on behalf of older Americans. I hope this hearing is the first of several on this important issue.

Item 2

COUNTY OF BERKS
OFFICE OF THE AGING
AREA AGENCY ON AGING

DONALD W. BAGENSTOSE
ANTHONY J. CARABELLO
VERNON K. SHAFFER
COMMISSIONERS

124 SOUTH 5TH STREET, READING, PA 19602
PHONE 378-1635

PETER D. ARCHEY
EXECUTIVE DIRECTOR

May 21, 1979

TO: Older Individuals and Organizations
Federal, State, and Local Elected Officials
Federal, State, and Local Appointed Officials
Health Insurance Companies and Providers
Community Organizations

FROM: Peter D. Archey

Attached for your review and consideration is a Position Paper calling for the elimination of Medicare co-insurance and deductibles.

As noted, the recommended elimination can be provided through a national health insurance program. It can also be accomplished without a full national health insurance package.

The situation needs change, not today or tomorrow, but yesterday!

Health care for older people, as currently structured, is a seller's market. The recommended changes will begin to provide a better consumer focus from both users and providers, producing an attitude of:

"I'm a customer, not a patient."

COUNTY OF BERKS
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PETER D. ARCHEY
EXECUTIVE DIRECTOR

POSITION PAPER ON ELIMINATING MEDICARE CO-INSURANCE AND DEDUCTIBLES

A Local Agency Viewpoint

Prepared by: Peter D. Archey
Executive Direc

Medicare is a health insurance program primarily for individuals age 65 or over. Some disabled persons under 65 may be covered. Although Medicare includes hospital, physician, and other health services, it covers only about 40% of the health care costs of older people. It is an unfulfilled promise. As currently operated, it remains far from the optimistic comment of President Lyndon Baines Johnson at the July 30, 1965 signing of the Medicare legislation, "No longer will Older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years".

Medicare, as currently administered and structured, is difficult to understand, confusing in its administration, and remains physician and hospital focused. The main reason for the confusion and complexity is the cost sharing system of co-insurance and the deductible payments, which have been part of the program since its conception. The co-insurance and deductible provisions are especially complicated and confusing. They produce a seller's market, weighted toward the providers benefit rather than the client. They produce a real or perceived need for supplemental insurance. They camouflage the real issues which are the number of services not currently Medicare covered/reimbursed and the lack of agreement on what are reasonable physician fees and ceilings.

POSITION

THIS PAPER STRONGLY SUPPORTS AND FORCEFULLY RECOMMENDS THE ELIMINATION OF THE CO-INSURANCE AND THE DEDUCTIBLE PROVISIONS OF MEDICARE. The elimination would remove the single largest problem area with the Medicare system and will focus on the real issues of health care for older people. Congress and the Administration need not wait for a national health insurance program. Medicare co-insurance and the deductibles can be eliminated now and should be.

This paper is written from a local community point of delivery view, where the older person's frustration with and inability to solve the co-insurance and the deductible problems are most visible and immediate. It focuses on the problems the current system produces in keeping people out of the health care system or severely frustrating them with it.

BACKGROUND

Medicare began with a $40 hospital deductible and a $10 co-insurance from the 60th to the 90th day. 1979 requires $160 hospital deductible and $40 co-insurance from the 60th to the 90th day. The Part B medical insurance began with a 20% co-insurance which has been retained. The original Part B $50 deductible has increased to $60. In addition, the original voluntary monthly premium of $3 has increased to $8.20 per month, which is also matched by general tax revenue.

Medicare cost sharing (co-insurance and the deductibles) are included according to the following reasoning:

1. If the individual has a financial interest in services, the individual will use services more wisely, will use the more appropriate services, and will not over-use health services.
2. Income is produced from the individual, rather than from the program.

As noted earlier, the complexities of co-insurance and the deductibles often are very confusing to older people. Local evidence is that many older people do not submit bills for payment and pay those bills out of pocket, which is an unnecessary cost to the individuals pockets and to their well being.

REASONS FOR ELIMINATION

Co-insurance and deductibles should be eliminated for the following reasons:

1. While they may be a deterrent to service use, this is usually at the price of low income people, those least able to afford deductibles and co-insurance. This obviously includes a large percentage of older people. They simply decide not to enter the service system or do not submit for valid reimbursement.

2. Older people do not control service delivery. Physicians do. It is estimated that approximately 80% of the health care expenditures are determined by a physician. More elderly are questioning physicians decisions; however, major impact of that questioning is considerably in the future, due to the difficulty in understanding medical technology, and to the traditional difficulty in not questioning physicians. As long as physicians control usage, perhaps they, rather than the individual, should bear the cost of over-utilization and unnecessary use of services.

3. For hospital stays, the Professional Standards Review Organizations (PSRO) produce the criteria for determining the length of stay which will be covered by Medicare. This holds true also for skilled nursing home settings. If the individual is determined to no longer need skilled care in a hospital setting, they have up to three days in which to be transferred to a lesser level of care. Medicare will no longer pay after that period of time. Therefore, some controls are built into Medicare hospitalization stays. The individual is not making that determination. The PSRO's or their delegates are.

4. The process and formula used to determine the reasonable charges and prevailing fees for physicians is too complicated to understand. If a doctor chooses not to take assignment, which means that he will not accept the Medicare reasonable charge, the individual can and usually is billed more than the maximum figure which Medicare will allow. The individual then is reimbursed only for 80% of the reasonable charge and is also liable for any additional fee which the physician can legally impose. In 1975, only 51.8% of the physicians were accepting Medicare assignments. Physicians maintain that the co-insurance and deductible maintain that Medicare fee structure is often 12-18 months behind in updating actual fees. The formula to determine the reasonable charge and prevailing fees is very complex. To para-phrase a friend, that formula can only be applied; it cannot be explained or understood. The local effect is that elderly are paying a larger percentage and Medicare less. (See Appendix A for example)

5. The need for filling in the co-insurance and deductibles for Medicare has given birth to the so-called Medi-gap insurance industry. The very fact that people are buying supplemental insurance to provide for those gaps in Medicare

defeats the very purpose for their introduction. Obviously, the cost sharing is simply transferred from Medicare to the individual buying supplemental insurance. An estimated 53-60% of elderly carry Medicare private supplemental hospital insurance with 12% having two or more policies. Medi-gap insurance has been the subject of recent U.S. Senate and House Hearings as fraud and deception have marked that industry. As noted at those hearings by Elizabeth Hanford Dole, Commissioner, Federal Trade Commission: "It is difficult enough for anyone to have a thorough understanding of Medicare's complex benefit structure and its gaps. Now add to that the bewildering variety of ways each different insurer fills some of those gaps. Then, when hospital and nursing home indemnity plans and dread disease contracts complicate the picture, comprehension, and comparison become almost impossible for consumers."

6. The individual is at the mercy of the market place and its cost increases. As health costs increase, especially hospital costs, the hospital deductible increases as does the co-insurance. The individual doesn't control those costs or increases; the health care market place does.

7. Cost sharing administration is complicated and introduces additional expenses. There is very little information available as to the income difference between the yield from co-insurance and the deductibles and the cost to administer them. It is known that the more complicated the co-insurance and deductibles the more expensive the administration. For example, Blue Cross/Blue Shield figures note that the so-called hospital plans run about 6% administrative costs while the more complicated physician and medical insurance run about 11%. In addition, Social Security, hospital social workers, congressional offices, and community agencies spend untold sums in cost and time working with older people and their relatives trying to explain and clarify an absurdly confusing benefit program.

SUMMARY

For the above reasons, this paper strongly supports and recommend the elimination of Medicare co-insurance and deductibles. They simply do not serve a major positive purpose for older people. They are a deterrent in that they may hinder low income people, obviously a large percentage of the elderly, from entering the service system. They produce major confusion and chaos in understanding the billing problems and the billing process. There is simply no reason to run a system which is so difficult to understand. It avoids the real issues as to what legitimate health care services for the elderly people should be and what are legitimate fees for physicians.

However, there is a major concern with both the amount and the source of income to be used to supplant or substitute for the co-insurance and deductible provisions. It is estimated that perhaps four billion dollars a year would be minimum needed to provide the substitution. While four billion dollars is a large amount of funds, it is less than 20% of the total current Medicare expenditures. It is less than 10% of total elderly health costs. It is less than 3% of the total health care expenditures for the nation.

It could be afforded preferably through general tax revenue, among the various options. There is a precedent for the use of general tax revenue in the current Medicare program, especially in Part B, the medical insurance. It would not eliminate the contributions of the elderly through the monthly premium for Part B and through the years that they, their friends, relatives, and employers contribute in payroll taxes, still the major income source for Medicare.

At a recent session provided to help older people better understand the current chaotic Medicare billing process and procedure, a senior advocate commented: "Why are people complaining about national health insurance red tape? What could be worse than what we have now?"

End the Medicare co-insurance and deductible mess. End it now! Health system change for older people does need national health insurance. But older people need change right now. Start with major revamp of Medicare by eliminating co-insurance and deductibles.

APPENDIX A

Examples are offered to highlight the problems, confusion, and frustration produced for older people and friends/relatives by Medicare co-insurance and deductibles.

Upon retirement, (using age 65, which is non-disability Medicare age eligibility) most elderly lose group company benefits. A 1978 Berks County survey showed 78% of a representative sample of employers do not provide any company paid insurance benefits or Medicare supplement for Medicare eligible retirees.

Usual supplemental coverage is: (current rates using a major insurance carrier)

Part B Medicare	$8.20 month	(individual payment required)
Private Part A Supplement	6.55 month	(individual option) (pays mainly co-insurance and deductibles)
Private Part B Supplement	5.05 month	(individual option) (pays mainly co-insurance but not $60 deductible)
Private Part B Extended Coverage	3.90 month	(individual option but must have A and B supplement first) (good primarily when high drug costs are involved. Also has $100 deductible)
	$23.70 month	
	x 12	
	$284.40 Annual Individual Cost	

NOTE: If spouse is Medicare eligible, a couple will be paying nearly $600 a year just for premiums for less coverage than they probably had before retirement, with those premium costs before retirement picked up in total or part by the company. In other words, less coverage and the premium cost paid out of pocket, when less money is available after retirement.

If the spouse is under 65, the cost is even higher as the spouse must be covered by an individual insurance plan (non-Medicare).

Billing Process: (If a doctor decides not to take assignment and the patient is billed directly. Doctor can change any fee he wishes; individual will receive only from Medicare 80% of Medicare reasonable charge.)

Physician charges patient	$1,000
Medicare reasonable charge	300
Minus $60 unmet deductible	60
	$ 740
Medicare pays 80% of $740 or	$ 592

Patient must submit bill to Medicare for the $592. If the patient has supplemental insurance from the same insurance carrier as Medicare, one billing process can also include request to 20% co-insurance (difference between $740 and $592). If the supplemental insurance company is different, a separate billing is involved.

On a $1,000 charge, the patient receives from Medicare 80% of Medicare ceiling.

Individual must pay:

Out of pocket difference between $1,000 and $800 or	$200
Out of pocket deductible	60
Out of pocket or supplemental insurance co-insurance (20% of $740)	148
Individual pays over and above Medicare	$408
Medicare pays 80% of $740 as shown above	592
	$1,000 Total

CONFUSING? ABSOLUTELY! AND THIS IS A RELATIVELY EASY EXAMPLE! ELDERLY OFTEN PUT BILLS IN A DRAWER AND DON'T EVEN BILL FOR WHAT THEY COULD RECEIVE. CO-INSURANCE AND DEDUCTIBLES PRODUCE A FRUSTRATING, CONFUSING, CHAOTIC SYSTEM WHICH IS A CONSUMER NIGHTMARE AND DISGRACE.

PDA/dla
5-11-79

APPENDIX B

References

Major reference sources are a H.E.W. "Discussion Paper on Cost Sharing and National Health Insurance" and a paper on "Cost Sharing" by the Committee for National Health Insurance. These papers include extensive bibliographies on the subject.

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PDA/dla
5-18-79

Item 3

NATIONAL COMMITTEE TO PRESERVE
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STATEMENT OF
MARTHA McSTEEN
PRESIDENT
THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

REGARDING
MEDIGAP INSURANCE PREMIUMS IN 1990

JANUARY 8, 1990

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The organization has no direct pecuniary involvement in the Medigap insurance industry, but as an organization representing about five million seniors, we are deeply concerned about the increases in Medigap policy premiums. Not only are we concerned about the erratic, and in some states dramatic, premium increases, we also must guard against some in the industry who might use the repeal of the catastrophic legislation as an opportunity to sell new and more expensive policies.

In an effort to help our members find their way through the Medigap maze, we have launched an educational campaign. We have developed an easy-to-use Medigap policy comparison chart which we plan to mail to our members free of charge. We have written a column which will appear in local newspapers across the country and we are working with the radio and TV media to advise seniors to seek insurance counseling before switching or upgrading their policies.

It may be superficially tempting to blame the repeal of the catastrophic coverage legislation for the dramatic increases in Medigap premiums. But a fair share of blame for these increases rests with this nation's continuing inability to curb medical inflation. This has caused all other health insurance rates to increase. Unchecked, medical inflation is undermining our public and private health insurance systems. For example, significant cost underestimates helped erode Congressional support for the catastrophic legislation. The underlying problem of medical inflation must be addressed as we look towards reforming our medical system.

We understand that some insurance companies are seeking Medigap rate increases of between 15 and 70 percent. These increases are similar to increases in 1989. According to a state-by-state survey released by the House Select Committee on Aging on November 2, 1989, increases in 1989 ranged from 10 percent in Massachusetts to 133 percent in Arizona. Well over half of the responding states indicated that Medigap prices increased up to 25 percent or more. While we were told by the industry that increases would have been worse had full hospitalization not been covered by Medicare in 1989, beneficiaries never saw the benefit of catastrophic legislation reflected in Medigap premiums.

While some degree of variability in rate increases is to be expected, it is impossible for consumers to ascertain what premium increase is justified and what is not. States vary considerably in their scrutiny of rate increases. Some states allow insurance rates to go up without prior approval. According to the Select Committee on Aging survey, two-thirds of the surveyed states do not require changes in rates for group Medigap insurance to be approved before going into effect. Over a third of the states do not require group policies to file their rates and rate changes with the state. And several states, including Alabama and the District of Columbia, do not require that rate changes - whether individual or group - be filed at all. Even in states that require a review before rate increases go into effect, the process varies widely. Some states conduct paper reviews, while a few have public hearings. The consumer tends to fare considerably better in states that have a thorough review process. Maryland, for example, cut in half the rate increase requested by Blue Shield after an extensive hearing and review process. Clearly, a more comprehensive and uniform process to scrutinize rate increases is called for.

The National Committee supports a strengthening and expansion of the 1980 Baucus amendment to the Medicare law governing Medigap policies. Rather than to serve as guidelines, it should be mandatory that Medigap insurance policies meet the requirements of the Baucus amendment. Further, each state should be required to set up a formal review process before accepting rate increases above Medicare inflation rates. Consumers should be provided an opportunity to be heard during a public hearing process and be able to request in writing a justification of rate increases.

In view of the GAO findings* that the suggested loss ratio of 60 percent or more for individual policies is often not adhered to among commercial insurance companies, the National Committee urges a tightening of the Baucus language. Standards should be set determining for what time period the loss ratio should be calculated and what the loss ratio should be.

For many people, insurance policies and the language associated with insurance coverage are confusing. Private insurance is not unique in this regard; unfortunately the same is true for the Medicare program. It is complex and baffling to many seniors. Until we develop more streamlined systems, we have a responsibility to fund insurance counseling programs to assist seniors through the system. Some states have excellent programs that can be used as models. A small percentage of Medicare dollars matched by state dollars could be used for this purpose.

The complexity of the Medicare program, its billing and reimbursement process, and the interfacing with private, supplemental insurance is emotionally and monetarily costly to most senior Americans. The National Committee believes that it is imperative that we simplify the process of billing and reimbursement and that educational materials be developed by the government, the insurance industry and consumer groups. The wide distribution of such materials allows intelligent decisions to be made concerning insurance needs.

The National Committee certainly believes that there is a strong role for private health insurance in this country. However, there is also an obvious need for further consumer education and protection.

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* GAO testimony, April 6, 1989, before the U.S. House of Representatives.

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